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	06/02/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, and record reviews, the facility failed to ensure staff developed and implemented a residentˆspecific care plan (a plan that detailed resident goals and care instructions for facility staff), for one of two sampled residents (Resident 1) when the care plan did not include instructions that directed Certified Nursing Assistants (CNAs) and Licensed Nurses (LNs) to assist Resident 1 with turning and repositioning. This failure had the potential to prevent Resident 1 from maintaining or attaining their highest practicable physical, mental, and psychosocial well-being. And resulted in the development of three pressure injuries (bed sores from pressure on the skin). Refer to F686Findings: A review of the facility's undated policy and procedure titled, Provisions of Quality of Care, indicated residents would receive treatment and care in accordance with the comprehensive person-centered care plan. A review of Resident 1's admission Record, dated 2/25/26, indicated admission to the facility with the diagnoses of myocardial infarction (a medical emergency also known as a heart attack), shortness of breath (inability to get enough air into the lungs), and presence of a left artificial hip joint (hip replacement). Resident 1 was their own decision maker and Family Member (FM) was the alternative decision maker (made decisions for Resident 1, when they could not make their own). A review of Resident 1's admission Minimum Data Set (MDS, an assessment tool), Section C, dated 3/4/26 and completed by MDS Nurse, indicated that Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment for memory or confusion) and scored an eight out of 15, which indicated Resident 1 required assistance with complex decision making. A review of Resident 1's admission MDS, Section GG, dated 3/4/26 and completed by MDS Nurse, indicated, Resident 1 had impairment (functional issue that affected a resident's daily life) to one lower extremity (leg), required substantial to maximal assistance (helper does more than half the effort) to roll from side to side in bed, wash their face, and comb their hair. A review of Resident 1's admission MDS, Section M, dated 3/4/26 and completed by MDS Nurse, indicated Resident 1 was at risk for developing Pressure Injuries (PI, damage to the skin and underlying tissue caused by staying in one position for too long). During an interview on 4/14/26 at 12:30 pm, Resident 1's family member (FM) indicated visiting Resident 1 in the facility almost daily. FM indicated, between 2/25/26 through 4/7/26, FM witnessed Resident 1 sit in the wheelchair for three hours or longer without any repositioning. FM stated, I've sat in the room for three hours or longer without anyone coming in to check on [Resident 1]. FM confirmed that Resident 1 could not turn or reposition herself without the assistance of facility staff. During an observation on 4/15/26 at 10:09 am, located in Resident 1's room, Resident 1 was lying on their back and their eyes were closed. CNA G entered the room at 10:14 am, and alerted Resident 1 and FM that CNA G was going to reposition Resident 1. CNA G provided almost all the help that was required to turn and reposition Resident 1. During a concurrent interview and record review on 5/21/26 at 10:10 am, with MDS Nurse and MDS Resource Nurse (RN), Resident 1's care plan titled, Potential for Pressure Ulcer Development (Pressure Ulcer also called PI), dated 2/28/26 was reviewed. MDS Nurse and MDS RN both confirmed that Resident 1 was at risk for developing PI's and that Resident 1's care plan indicated that staff would encourage Resident 1 to reposition as often as tolerated. MDS RN confirmed Resident 1's care plan had not included specific (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident instructions on the steps that were to be taken to prevent Resident 1 from developing PI's. MDS RN stated, [Resident 1's] care plan should have reflected staff will assist with turning and repositioning as tolerated, knowing that [Resident 1] can't reposition on [their] own.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide one out of two sampled residents (Resident 1) with the necessary care and services to prevent the development of three facility acquired Pressure Injuries (PI-skin and tissue loss with exposed fat, muscle, or bone) a Stage 4 PI on the coccyx (tailbone), a Deep Tissue Pressure Injury (DTI, serious type of PI that caused damage to the tissue or muscle) to the posterior (back of) right heel, and a DTI to the tip of the right big toe when: 1. Licensed Nurses (LN) and Certified Nurse Assistants (CNA) did not identify the progression of skin changes, over a 24 day period, which led to the discovery of the PI's at advanced stages. 2. The facility had not ensured Resident 1 was repositioned and turned per the facility's policy and procedure (P&P). 3a. There was a 14 day delay in providing Resident 1 with a Low Air Loss (LAL, a pressure-redistributing medical air bed that alternates pressure relief by airflow to maintain the temperature of the skin, keep skin dry and reduce areas of pressure to the skin) mattress after the coccyx PI was identified.3.b There was a 10-day delay in providing Resident 1 with an evaluation from the Wound Doctor (WD, a physician who specializes in the management and treatment of PI's).3c. The facility's Infection Preventionist (IP) did not follow up on a Physician ordered laboratory test result resulting in an infection to the coccyx PI left untreated. The cumulative effects of these failures caused Resident 1 actual harm by the development of three PI's, debridement (surgical procedure to remove dead tissue), and required a general acute care hospital admission. Findings: 1. A review of Nursing 2017, the National Pressure Injury Advisory Panel (NPIAP [formerly known as NPUAP] an internationally used, and professionally recognized pressure injury) resource), dated 2017, Pressure Injures are staged to indicate the extent of tissue damage. Stage 4: Full-thickness skin and tissue loss with exposed or directly palpable (physically touched) fascia (fat layer), muscle, tendon, ligament. Cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (wound edge curled inward), undermining (cave-like pocket of space in the tissue), and/or tunneling (a passageway) often occur. Depth varies by anatomical location. If slough (white or yellow dead tissue) or eschar (thick, hard, often black in color, dead tissue) obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury (PI): Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Deep Tissue Pressure Injury (DTI): Intact or non-intact skin with localized area of persistent non-blanchable (stayed red when pressure was applied) deep red, maroon, purple discoloration or epidermal (outer layer of skin) separation revealing a dark wound bed or blood-filled blister. A review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention and Management, dated 2026, provided by Director of Nursing (DON) A, indicated, the facility was committed to the prevention of avoidable PI's. The P&P indicated, Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors. The P&P indicated, 3 c. Licensed Nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. The P&P indicated, 3 e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. The P&P indicated, The RN [Registered Nurse] Unit Manager, or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document summary of findings in the medical record. A review of Resident 1's admission Record, dated 2/25/26, indicated admission to the facility with the diagnoses of myocardial infarction (a medical emergency also known as a heart attack), shortness of breath (inability to get enough air into the lungs), and presence of a left artificial hip joint (hip replacement). Resident 1 was their own decision maker and Family Member (FM) was the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	alternative decision maker (made decisions for Resident 1, when they could not make their own). A review of the admission Minimum Data Set (MDS, an assessment tool), Section C, dated 3/4/26, indicated that Resident 1 had a Brief Interview for Mental Status (BIMS, an assessment for memory or confusion) and scored an eight out of 15, which indicated Resident 1 required assistance with complex decision making. A review of admission MDS, Section GG, dated 3/4/26, indicated, Resident 1 had impairment (functional issue that affected a resident's daily life) to one lower extremity (leg), required substantial to maximal assistance (helper does more than half the effort) to roll from side to side in bed, wash their face, comb their hair, sit up in bed, and transfer from the bed to a chair. A review of the admission MDS, Section M, dated 3/4/26, indicated that upon admission to the facility, Resident 1 did not have any PI's, was at risk for developing PI's, did not have any foot problems, and had moisture associated skin damage (MASD, weakened skin caused by prolonged exposure to moisture). The MDS indicated that Resident 1 was not on a turning or repositioning program. During a concurrent interview and record review on 5/20/26 at 10:00 am, with Assistant Director of Nursing (ADON), Resident 1's progress notes titled, Nurses Notes, written by LN K, dated 2/25/26 was reviewed. ADON confirmed the Progress Note, dated 2/25/26 indicated, Resident 1 was admitted to the facility on [DATE] and had no PI's. During a concurrent interview and record review on 5/20/26, at 10:10 am, with ADON, Resident 1's Nursing-Skilled Service Note-V2 (daily nursing notes), dated 2/25/26 through 3/16/26 were reviewed. ADON confirmed that the daily nursing notes had not reflected any changes to Resident 1's skin and the skin assessments indicated Resident 1's skin was normal without any indications of PI's, during that time frame. ADON confirmed, the daily nursing notes required a visual inspection of the skin. During a concurrent interview and record review on 5/20/26 at 10:00 am, with ADON, Resident 1's Nursing-Weekly Summary-V4, dated 3/9/26 and another weekly summary dated 3/17/26 and time stamped at 7:08 am, were reviewed. ADON confirmed both Weekly Summaries were completed by LN E, a head-to-toe skin assessment (assessing all the skin from the top of the head to the toes) was completed, and there were no identified concerns regarding Resident 1's skin. During a concurrent interview and record review on 5/20/26 at 10:40 am, with ADON, Resident 1's Nursing-Weekly Skin Alteration (Non-Pressure) Evaluation (an assessment that described changes that were not PI), completed by LN E, dated 3/17/26 and time stamped 11:34 pm, (16 hours and 26 minutes after LN E's Weekly Summary), indicated LN E assessed Resident 1's sacrum area (the small of the back just above the coccyx), and there was a wound (LN E did not identify the wound as a PI) and documented the wound was not located in a pressure area (an area of skin that is close to the bone where PI's form). LN E measured the wound to be 1.66 centimeters (cm, two and a half cm equals about one inch) in length, 1.56 cm in width, and 0 cm in depth. LN E described the tissue loss as partial thickness and purple in color. LN E called the facility's on-call Physician, obtained treatment orders, and the Physician had recommended the facility's Wound Doctor (WD) follow up and provide treatment. The note did not indicate that LN E notified the WD. ADON confirmed, LN E's 3/17/26 Nursing-Weekly Skin Alteration (Non-Pressure) Evaluation was incorrect and confirmed, the wound was located on the coccyx, not on the sacrum, and was located in a pressure area. A review of Resident 1's progress note titled, Alert Note, dated 3/21/26, written by LN I and time stamped 10:48 am, indicated, Coccyx wound continues with no improvement. New wound DTI to Rt [right] foot, new pressure sore to rt heel and top of right toe per wound care nurse. Boots [foam heel protector that elevated the feet off of the bed] and resident to be turned q [every] 2 hours for offloading [kept the heels elevated]. A review of Resident 1's progress notes titled, Skin/Wound Note, dated 3/21/26, written by Treatment Nurse (TN) D and time stamped 11:34 am, indicated TN D assessed a DTI to the right posterior (back of) heel that measured 5 cm in length and 5 cm in width. Skin intact but is deep red/purple in color. MD [Physician] notified with new order for soft boots to both feet. During an interview on 5/20/26 at 11:57 am, CNA J indicated when a shower or bath was provided to residents, the CNA looked at the resident's skin. CNA J stated, We look for any skin concerns seen on the resident, bruises, abrasions, looking for open (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wounds, rashes, skin tears, or if the skin is red. It's documented on the shower sheet and we notify the nurse. CNA J confirmed that anytime there was an observed change noted to the resident's skin, the CNA would alert the resident's nurse. During a concurrent interview and record review on 5/20/26 at 12:53 pm, with Medical Records (MR) and Director of Staff Development (DSD), both indicated there were two shower sheets for Resident 1, between the dates 2/25/26 and 4/7/26, even though Resident 1 was supposed to be showered twice a week, dated 3/4/26 and 3/11/26. Upon review both shower sheets indicated that Resident 1 had refused to be showered on those days. MR stated regarding the missing shower sheets, We usually don't keep them, they are internal documents. During a concurrent interview and record review on 5/20/26 at 2:21 pm, with TN C, Resident 1's progress notes titled, Nurses Note, dated 3/11/26 was reviewed. TN C confirmed, the Nurses Note indicated Resident [1] had refused a shower multiple times, no new skin issues. During an interview on 6/2/26 at 1:47 pm, LN E was asked how LN E obtained assessment information for skin assessments. LN E stated, I rely heavily on my CNAs to report skin changes for my residents, they change them, they shower them. LN E indicated that she documented skin assessments based on information from previous skin assessment information that was obtained from the electronic medical record (EMR) and stated, I look at the admission note, treatment orders, and skin and wound evaluations and LN E confirmed, she documented that Resident 1 had no skin problems but had never visually inspected Resident 1's skin, until she identified the coccyx PI on 3/17/26. A review of Nursing 2026, dated 7/1/2010, [NAME] and [NAME], Inc; 2008, (a nationally recognized premier healthcare and medical publisher) indicated, A SKIN ASSESSMENT captures the patient's general physical condition, based on careful inspection and palpitation (feeling/touching) of the skin and documentation of your findings. A review of Resident 1's initial Wound Assessment Details, completed by the WD, dated 3/27/26 indicated, WD had assessed Resident 1, 10 days after Resident 1 had developed three PI's that were acquired in the facility, and it was the WD's first time assessing them. The WD note indicated Resident 1 had an Unstageable, open area to the coccyx that measured 3 cm in length, 4.5 cm in width and 0 cm in depth. The WD note indicated that WD performed a surgical debridement (removal of dead tissue using sharp instruments like a scalpel knife and scissors), at Resident 1's bedside on 3/27/26. The Unstageable PI to the coccyx was then considered a Stage 4 PI and measured 3 cm in length, 4.5 cm in width, and 1.1 cm in depth. The WD note indicated that Resident 1 had a DTI located on the bottom, posterior of the right heel that measured 3.5 cm in length, 5 cm in width, and 0 cm in depth. The WD note indicated Resident 1 had a DTI on the outer tip of the right big right toe that measured 0.4 cm in length, 0.3 cm in width and 0 cm in depth. Additionally, the WD note indicated Resident 1 had moisture associated skin damage (MASD, skin damage caused by prolonged moisture to the skin) to the left gluteal fold (the crease between the bottom of the buttocks and upper thigh). 2. A review of the facility's P&P titled, Turning and Repositioning, dated 2025, provided by the Director of Staff Development (DSD) indicated, It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. The P&P indicated that all residents at risk of, or with existing pressure injuries, would be turned and repositioned. The P&P indicated, The frequency of turning and repositioning will be documented in the resident's plan of care. The P&P indicated that repositioning techniques included placing the resident in a side lying position, utilizing pillows or wedges for positioning and pressure reduction, and elevating the heels with pillows to keep the heels off the surface of the bed. The P&P indicated, when the resident was in a chair, repositioning techniques included encouraging pressure relief every if 15 minutes if the resident was able and if the resident was unable to make position changes, facility staff would reposition the resident every hour. During an interview on 4/14/26 at 12:30 pm, Resident 1's FM indicated visiting Resident 1 in the facility almost daily. FM indicated between 2/25/26 and through 4/7/26, FM witnessed Resident 1 sitting in the wheelchair for three hours or longer without any facility staff providing Resident 1 with repositioning. FM stated, I've sat in the room for three hours or longer without anyone coming in to check on [Resident 1]. During a concurrent observation of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1 and interview with CNA G on 4/15/26 at 10:09 am, in Resident 1's room, Resident 1 was lying on their back and their eyes were closed. CNA G entered the room at 10:14 am, and indicated CNA G was going to reposition Resident 1. CNA G provided almost all the help that was required to turn and reposition Resident 1 because Resident 1 was unable to reposition or turn herself. During a concurrent interview and record review on 4/15/26 at 10:26 am, with CNA G, the CNA Task section (the section of the medical record where the CNA documented the care that was provided) of Resident 1's medical records were reviewed. CNA G indicated the CNAs should document turning and repositioning residents every two hours in the CNA Task section and stated, I document every two hours in the computer, I don't document as it happens, I document it all when I have a chance. CNA G confirmed there was no evidence located in the CNA Task section that indicated Resident 1 was being turned and repositioned every two hours. During an interview on 5/19/26 at 3:31 pm, LN H indicated that between 3/8/26 and 3/14/26, one week prior to the identification of Resident 1's Stage 4 PI, CNA F had verbalized not changing Resident 1's brief (adult diaper) for one eight-hour shift and LN H had provided CNA F with verbal education on the importance of repositioning and turning Resident 1 every two hours and the importance of changing the brief, even if the brief was not soiled. During a concurrent interview and record review on 5/19/26 at 3:52 pm, CNA F confirmed providing care to Resident 1 in the past and stated, I don't document that I turn them [the residents] every two hours. CNA F indicated there was an Attestation (a formal statement, located in the CNA Task section, that indicated the CNA repositioned and turned Resident 1 every two hours, during their shift) and CNA F had electronically signed it. CNA F was asked to review the Attestation in Resident 1's EMR and CNA F confirmed there was no Attestation located in the CNA Task section of the EMR. CNA F confirmed there was no documentation present that CNA F provided Resident 1 with turning or repositioning. CNA F confirmed that CNA F had not changed Resident 1's brief for the entire eight-hour shift because it was not soiled and had not visualized the skin on Resident 1's buttocks that day. CNA F could not recall the exact date and confirmed LN H had provided CNA F verbal education regarding repositioning and turning Resident 1 every two hours (between 3/8/26 and 3/14/26). During an interview on 5/20/26 at 2:21 pm, TN C was asked what the facility did to prevent PI's from developing for at risk residents. TN C stated, I educate the CNAs to float heels (elevating the feet so the heels are not in contact with the mattress) with two pillows, turn and reposition every two hours, and that most residents are at high risk. TN C indicated that verbal instruction to the CNAs was informal and not documented. TN C confirmed that not turning or repositioning a resident increased the risk for developing a PI. During a concurrent interview and record review on 5/21/26 at 8:44 am, with MDS Nurse and MDS Resource Nurse (RN), Resident 1's admission MDS, Section GG, completed by MDS Nurse, dated 3/4/26 was reviewed. MDS Nurse confirmed, Section GG indicated, Resident 1 had a loss of function to one leg and required substantial to maximal assistance from facility staff to comb hair, wash face, and to roll from side-to-side while in bed. MDS Nurse confirmed, the admission MDS, Section M, completed by MDS Nurse, dated 3/4/26, indicated Resident 1 was at risk for developing PI's and did not have any PI's upon admission to the facility. MDS RN indicated turning and repositioning residents was considered basic routine care and should be provided to all residents. During a concurrent interview and record review on 5/21/26 at 10:10 am, with MDS Nurse and MDS RN, Resident 1's care plan (a resident specific plan that outlined how staff should support and care for the resident) titled, Potential for Pressure Ulcer Development (Pressure Ulcer was another term for PI), dated 2/28/26, was reviewed. MDS Nurse and MDS RN both confirmed, Resident 1's care plan included the risk factor of being at risk for developing PI's and that the care planned interventions included that staff would encourage Resident 1 to reposition as often as tolerated which was inconsistent with Resident 1'a ability to reposition or turn herself. MDS RN confirmed Resident 1's care plan had not included resident specific instructions on the steps that were to be taken to prevent Resident 1 from developing PI's. MDS RN stated, [Resident 1's] care plan should have reflected staff will assist with turning and repositioning as tolerated, knowing that [Resident 1] can't reposition on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	[their] own. During a concurrent interview and record review on 5/22/26 at 9:56 am, with Infection Preventionist (IP), Resident 1's CNA documentation record titled, Documentation Survey Report, dated 2/25/26 through 4/30/26 was reviewed. IP confirmed that the Documentation Survey Report, was the information that the CNAs documented in the CNA Task section and it did not indicate that the CNAs had turned or repositioned Resident 1. IP indicated that the section titled GG-Roll left and Right, indicated how much assistance the CNAs gave to Resident 1 when rolling from side to side in bed. IP was asked to show documented evidence that CNAs had turned and repositioned Resident 1. IP indicated there should have been a CNA task list in the EMR, but this task was not available in Resident 1's EMR, and that was where the CNAs documented. IP, stated I don't see it under the task list. IP indicated the task for CNAs to reposition and turn Resident 1 should have been created by the DSD and included in the CNAs task list to do and was not, therefore there was no documented evidence to show Resident 1 had been repositioned or turned every two hours. During an interview on 5/22/26 at 11:48 am, DSD was asked who reviewed the CNA's documentation. DSD stated, I don't know how to look at the notes, I don't review the CNA documentation, and I thought [IP] was auditing it, but I'm not sure. 3a. A review of the facility's P&P titled, Pressure Injury Prevention and Management, dated 2026, provided by DON A, indicated, interventions for promoting wound healing included, 4 c Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic and routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal [bowel movements] contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Provide non-irritating surfaces; and v. Maintain or improve nutrition and hydration status where feasible. A review of the facility's undated P&P titled, Wound Treatment Management, provided by DON A, indicated that the facility promoted wound healing and treatment decisions would be based on the characteristics (appearance or condition) of the wound which included presence of an infection. A review of Resident 1's Physician's order, dated 3/25/26, indicated that a LAL mattress was ordered for wound care and management, (eight days after Resident 1's coccyx PI was identified). During a concurrent interview and record review on 5/1/26 at 12:42 pm, Maintenance Director (MD) was asked to describe the protocol for obtaining an LAL mattress. MD indicated when nurses requested an LAL mattress MD completed a work order and would then retrieve the LAL mattress from their shed and set it up for the resident. Work orders were reviewed with MD from 2/25/26 through 4/7/26 to determine what date Resident 1 had received the LAL mattress. MD indicated he had not created a work order and was unable to confirm what date Resident 1 had been provided with an LAL mattress. During an interview on 5/1/26 at 3:01 pm, DON A and TN D both confirmed that the LAL mattress was provided to Resident 1 on 3/27/26, 11 days after Resident 1 developed a Stage 4 PI and three days after the Physician's order was written. DON A stated, I would have liked it to have been sooner. DON A was asked if Resident 1 could have benefited from the use of an LAL mattress prior to the development and discovery of the three PI's and DON A did not provide a response. 3b. During a concurrent interview and record review on 5/20/26 at 10:40 am, with ADON, Resident 1's Nursing-Weekly Skin Alteration (Non-Pressure) Evaluation, completed by LN E and dated 3/17/26 was reviewed. ADON indicated, LN E had identified an open area to Resident 1's sacrum area. LN E called the Physician, obtained treatment orders, and the Physician had recommended the facility's Wound Doctor (WD) follow up and provide treatment. The note did not indicate that the WD had been notified. During an interview on 5/1/26 at 10:54 am, WD confirmed that on 3/27/26 (10 days after the Physician ordered a WD evaluation of the coccyx PI), was the first time WD had assessed Resident 1's coccyx PI and stated, I saw her when they notified me. WD was not able to recall what date the facility notified WD or who had notified him. During a concurrent interview and record review on 5/1/26 at 3:28 pm, with DON A, Resident 1's progress notes titled, IDT (Interdisciplinary Team, facility supervisors/managers meet to discuss resident care concerns and implement interventions), (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	dated 3/19/26, and completed by DON A, indicated Resident 1 would be seen by the WD on 3/20/26. DON A confirmed, the first documented visit by the WD for Resident 1's coccyx PI was on 3/27/26. DON A was asked why there was a delay in the WD seeing Resident 1. No response was provided. 3c. A review of the Physician's Progress Note, with the service date of 3/30/26 and signed by Resident 1's Physician on 4/2/26, indicated that the information in the progress note had been obtained over a period of four days. The progress note indicated nursing staff had reported a significant change of condition and worsening of Resident 1's acquired coccyx PI. The progress note indicated there was significant drainage (liquid draining from wound), tissue sinking (the center of the wound drops below the level of surrounding healthy tissue and can be caused by poor healing, tissue death, or infection), and appeared to be infected. The progress note indicated the wound bed (the deepest part of the wound) contained slough (soft yellow or white dead tissue), pus (thick, cloudy or white drainage), redness, and a foul odor that was consistent with an infection. The progress note indicated the Physician ordered a wound culture (a laboratory test that identifies the specific bacteria and what antibiotics would work on that particular bacteria that is causing an infection) of the coccyx PI that was to be done on 3/30/26. On 3/31/26, a preliminary report was faxed to the facility (generally, cultures take about 3 to 5 days to grow before a final report is available however, around day 2 an early report of the bacteria most likely causing the infection is provided by the lab, in case the physician wants to get antibiotics started). The preliminary results were communicated to the WD. The Physician's progress note had not indicated what bacteria was causing the infection or that antibiotics were to be started for Resident 1. A review of Resident 1's care plan titled, Stage 4 PI, dated 3/30/26, indicated, the facility would obtain laboratory tests as ordered and report the results to the Physician. The care plan was updated on 3/31/26 and indicated that the preliminary report from the lab for the results for Resident 1's wound culture contained 100,000 colonies (a term for how many bacteria were visualized growing together and was at a level consistent with infection) of mixed pathogens (a term used when multiple infectious agents such as viruses, bacteria or fungus are seen growing together in one colony). During a concurrent interview and record review on 5/20/26 at 2:21 pm, with TN C and ADON, Resident 1's progress notes titled, Nursing Notes, completed by TN C, dated 4/2/26 and timestamped 12:14 pm, was reviewed. TN C confirmed the progress note indicated Resident 1's preliminary wound culture results were back but provided no date that the facility received the results, that the WD was notified, and that TN C was waiting for a reply from the WD. TN C was asked when or if Resident 1 had been given antibiotics for the coccyx PI infection and TN C was unable to answer. Resident 1's progress note titled, Nurses Notes, completed by TN C, dated 4/2/26 and time stamped 3:35 pm, was reviewed with ADON. ADON indicated TN C's Nurses Notes reflected that the WD recommended an antibiotic called Bactrim (a broad spectrum antibiotic that kill most types of bacteria) but WD had not actually given the order. The note indicated that the WD said the antibiotic needed to be ordered by Resident 1's primary care Physician. The note indicated that TN C had notified the IP and DON A. TN C could not confirm if TN C had followed up with Resident 1's primary care Physician with the WD's recommendation to start Bactrim. ADON reviewed all of Resident 1's discontinued orders from 4/2/26 through 4/7/26 and confirmed there had been no order for Bactrim. During a concurrent interview and record review on 5/20/26 at 3:43 pm, with IP, Resident 1's Physician orders, dated 4/2/26 through 4/7/26 were reviewed. IP confirmed there was no order for Bactrim and indicated that until the final wound culture report was available, Resident 1's primary care Physician would not likely order an antibiotic. IP was asked if there was a final wound culture report and IP confirmed there was no final wound culture report and indicated that the facility had not received it. IP confirmed the final culture report was not followed up on and went unrecognized, therefore, no antibiotics to treat Resident 1's Stage 4 PI infection were ever ordered. A review of Resident 1's, Skin/Wound Note, completed by TN D, dated 4/3/26, indicated the WD had assessed Resident 1's Stage 4 PI to the coccyx and it had increased in size and measured 3.5 cm in width, 5.5 cm in length, 5 cm in depth and contained 2 cm of undermining (tissue damage that extended beneath (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the intact skin at the wounds edge). The DTI to the posterior right heel had increased in size and measured 3 cm in width, 4.5 cm in length, and 0 cm in depth. There was no documentation present which indicated the status of the DTI located on the tip of Resident 1's right big toe. A review of the hospital's History and Physical (H&P), dated 4/7/26, indicated Resident 1 was admitted to the hospital on [DATE] due to an infected sacral wound (the coccyx, sacral, and sacrum are all close in proximity and the terms are often interchanged) that required treatment with two different IV (intravenously, to be administered into the vein) antibiotics (Vancomycin and Zosyn, considered strong broad spectrum antibiotics). The H&P indicated that Resident 1 required .aggressive wound care. to be performed two times a day, close monitoring, and due to the infected Stage 4 PI, Resident 1 had the potential to develop sepsis (a life-threatening infection) and sustain life-threatening deterioration (decline in health status). A review of Resident 1's, Wound Care Note, completed by the hospitals Doctor of Osteopathic Medicine (DO, a doctor that has specialized training in the musculoskeletal [muscle and bones] system), dated 4/8/26, indicated Resident 1's Stage 4 PI measured 4 cm in width, 5 cm in length, and 7 cm in depth with 3 cm of undermining. The wound bed was described as containing 75 percent slough, the coccyx bone could be felt, there was a foul odor coming from the PI, and that the skin surrounding the PI was moderately red. The right posterior heel was described as an Unstageable PI that was 3 cm in width, 2 cm in length, 0 cm in depth and 100% of the posterior heel PI was covered in black dead tissue.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record reviews, the facility did not ensure one of two sampled residents (Resident 2) was free from accident hazards when Treatment Nurse (TN) C used an oil-based product on a resident that received oxygen (extra air that was administered through a tube into the nose and was highly flammable). This had the potential to cause an injury and a decline in physical, mental, and psychosocial well-being. Findings: A review of the undated owner's manual, titled 5-Liter Oxygen Concentrator (the name of the equipment that delivered Resident 2's oxygen), indicated, substances that contained oil could cause a fire and should be kept away from all oxygen equipment. A review of the facility's undated policy and procedure (P&P) titled, Oxygen Administration, indicated, facility staff would take precautions to prevent fires when oxygen was in use. A review of Resident 2's admission Record, dated 9/6/24, indicated admission to the facility on 9/6/24 with the diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that made it difficult to breathe) and acute (sudden) and chronic (on going) respiratory failure (inability to get enough oxygen into the lungs) with hypoxia (the body does not get enough oxygen to function properly) and hypercapnia (elevated levels of carbon dioxide in the blood stream). Resident 2 was their own responsible party (decision maker). A review of Resident 2's Annual Minimum Data Set (MDS, and assessment tool), dated 5/1/26, indicated that Resident 2 received oxygen therapy. During an observation on 4/15/26 at 11:15 am, with TN C, Resident 2's room was observed and next to Resident 2's bed was an oxygen concentrator (a machine that delivered oxygen), it was on, and was set at 3 liters per minute (a moderate flow oxygen). Resident 2 was lying in bed and wearing a nasal cannula (a tube that connected to the concentrator and delivered oxygen to Resident 2 through the nose). TN C was observing Resident 2's buttocks, and asked Resident 2 if they had any allergies to zinc oxide (a thick cream that protected the skin from moisture) or petroleum jelly (a thick gel made from oil and wax). Resident 2 stated, no. TN C was observed mixing the zinc oxide and petroleum jelly together and applied the mixture to Resident 2's buttocks. During an interview on 4/15/26 at 12:45 pm, TN C was asked if it was contraindicated (not safe) to use petroleum jelly on residents who received oxygen. TN C stated, yes it can be applied to the skin, I put it on her bottom, not at her nose. During an interview on 4/15/26 at 3:49 pm, Director of Nursing A confirmed, petroleum jelly could not be utilized on residents who received oxygen because it was a fire hazard and stated, It's not safe.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interviews and record reviews, the facility failed to ensure two Treatment Nurses (TNs are also Licensed Nurses) and three Certified Nursing Assistants (CNAs) possessed specific competencies and orientation (a measurable pattern of knowledge and behaviors required to provide care) and skill sets necessary to provide safe and effective care to the residents when the facility did not complete or maintain competency evaluations. This failure had the potential to place residents at risk for avoidable harm due to improper assessments, delayed recognition of changes in condition, and inadequate delivery of required care.Findings: A review of the facility's policies and procedures (P&P) titled, Competent Nurse Staffing, revised 10/1/25, indicated, facility staff would demonstrate appropriate skills and competencies that were necessary to provide care and services to the residents (some examples of care and services the LN provided to residents included administering medication, obtaining Physician orders, providing wound care, performing accurate assessments, documenting, and recognizing changes in condition). A review of the facility's undated P&P titled, Orientation, indicated the facility would implement (carry out or start) and maintain an effective orientation process for all new and contracted (worked in the facility and employed through a different company commonly called registry) employees. The P&P indicated the new staff member would receive a preceptor (experienced professional that provided training) who would verify that the new staff member was competent in a skill. The P&P indicated, the initials of the preceptor indicated competency. The P&P indicated the Director of Staff Development (DSD) was responsible to ensure orientation plans were maintained, and submitted to the Human Resource Department once completed. During a concurrent interview and record review on 5/21/26 at 2:43 pm, with Assistant Director of Nursing (ADON), TN C's employee file was reviewed. TN C's hire date was 3/17/26. ADON confirmed, there were two competencies dated 3/17/26 titled, Hand Hygiene (cleansing hands) and Donning and Doffing Personal Protective Equipment (putting on and taking offing gloves, isolation gowns, and wearing masks correctly), and a Wound Care Competency Assessment, dated 4/26/26 that was present in TN C's employee file. ADON confirmed, there were no other competencies present such as LN duties of administering medication, obtaining Physician orders, performing accurate assessments, documenting, and recognizing changes in condition. During a concurrent interview and record review on 5/21/26 at 3:04 pm, with Licensed Nurse (LN) H, CNA F's employee file was reviewed. CNA F's hire date was 1/27/26 and LN H confirmed, at that time, LN H was the Director of Staff Development (DSD). DSD reviewed the document New Employee Orientation Agenda, dated 1/27/26 and confirmed, the section titled, Day 2, which included training topics to be provided, included training on the CNA job duties, resident rights, dementia (memory loss), residents that were choking, and the facility's P&P on turning and repositioning residents, was blank and not signed by the instructor. LN H indicated that orientation to the facility was done at a different facility and it was not her responsibility to provide orientation to newly hired staff. LN H was asked who was responsible to ensure orientation forms were completed and training had been provided and LN H did not provide an answer. During a concurrent interview and record review on 5/21/26 at 3:00 pm, with the Assistant Director of Nursing (ADON), TN D's employee file was reviewed. TN D's hire date was 2/16/26 and ADON confirmed, there were two competencies dated 2/16/26 and 3/17/26 titled, Hand Hygiene and Donning and Doffing Personal Protective Equipment. ADON confirmed, there were no other competencies present such as LN duties of administering medication, obtaining Physician orders, performing accurate assessments, documenting, and recognizing changes in condition. During a concurrent interview and record review on 5/21/26 at 3:36 pm, with ADON and Scheduler (SCH), CNA K's employee record was reviewed. SCH confirmed that CNA K was not an employee of the facility and worked at the facility through a registry and was not able to provide CNA K's first date working in the facility. ADON reviewed CNA K's Skills Checklist, dated 9/27/23 and confirmed, the Skills Checklist, was a (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-evaluation (a tool used to self-identify and evaluate strengths, abilities, and area for improvement) and there was no competency check list that had been performed by the facility. During an interview and record review on 5/22/26 at 10:15 am, DSD and SCH were asked to review CNA L's employee file. SCH indicated that CNA L was registry, her first day working in the facility and providing care to the residents was on 5/20/26. DSD confirmed there was no employee file, or skills check list for CNA L and that SCH would reach out to the registry to obtain an employee file. DSD confirmed there were no competencies or skill checklists available to review for TN C, TN D, and CNA K. DSD was asked who was responsible to ensure CNAs and LNs had complete competency check lists. DSD indicated, she was responsible for the CNAs, and the Director of Nursing or Assistant Director of Nursing was responsible for the LNs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record reviews, the facility failed to ensure that medication administered to one out of two sampled residents (Resident 2) was safe when Treatment Nurse (TN) C provided medication without a Physician's order. This had the potential to cause a decline in resident health status.Findings: A review the facility's policies and procedures (P&P) titled, Wound Treatment Management, dated 2025, indicated, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. A review of the job description, titled, Treatment Nurse, dated 2003, indicated, the TN would provide skin care to the residents under the direction of the Physician. A review Resident 2's admission Record, dated 9/6/24, indicated admission to the facility on 9/6/24 with the diagnoses of hypertension (high blood pressure) and chronic pain. Resident 2 was their own responsible party (made own decisions). A review of Resident 2's care plan (a documented that described resident goals and care instructions for facility staff) titled, Resident has a rash, dated 4/20/26, indicated Resident 2 had a rash underneath both breasts and facility staff would administer treatment per the Physician's order. During a concurrent observation, interview, and record review, on 4/15/26 at 11:15 am, with TN C, Resident 2's Physician's orders were reviewed prior to entering Resident 2's room. TN C confirmed there were no skin treatment orders present. TN C was observed assessing Resident 2's skin. TN C indicated, underneath both of Resident 2's breasts and the apron area (the fold or overhanging fat that hung down over the lower abdomen) were assessed to be red, blanchable (the skin turned white when pressure was applied to the red area), and the skin was intact (not open). TN C applied an antifungal cream that contained miconazole (a medication used to treat skin infections that were caused by yeast) underneath both of Resident 2's breasts and nystatin powder to apron area. During an interview on 4/15/26 at 12:45 pm, TN C confirmed, that she applied an antifungal cream and powder under Resident 2's breasts, without a Physician's order. TN C indicated, after TN C assessed a resident's skin, TN C had decided what treatment was needed without consulting Resident 2's physician. TN C indicated that she performed the treatment that she felt was appropriate, then called the Wound Doctor (WD) afterwards with TN C's recommendations for treatment and would then obtain a Physician's order. TN C indicated that TN C would provide a different treatment to the residents if the residents primary care Physician or WD did not agree with the treatment she had provided. During an interview on 4/15/26 at 3:39 pm, Director of Nursing (DON) confirmed, a Physician's order was required prior to the administration of any treatment or medication. During a concurrent interview and record review on 4/15/26 at 4:23 pm, with DON and Infection Preventionist (IP), Resident 2's Physician's orders were reviewed. Both DON and IP confirmed, there was no Physician's order present in Resident 2's medical records for the use antifungal cream or powder and indicated that TN C should of obtained a Physician's order prior to putting the antifungal cream and powder on Resident 2. During an interview on 5/1/26 at 10:54 am, the facility's WD indicated, when the TN performed a skin assessment and identified an issue, the TN should call WD for treatment recommendations. WD indicated that the TN should provide his recommendations to the resident's primary care Physician and obtain an order for treatment prior to providing any treatment. WD confirmed, TN C did not call WD with Resident 2's skin assessment or for treatment recommendations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not ensure infection control practices were maintained when: 1. Certified Nurse Assistants (CNAs) did not wear required personal protective equipment (PPE, gowns, gloves, and masks) during resident care for two out of two sampled Residents (Residents 1 and 2).2. Treatment Nurse (TN) C pulled her face mask down past her mouth and pulled it back up to cover mouth with dirty gloves while providing care to one out of two sampled residents (Resident 2).3. TN C did not maintain infection control prevention before or after providing wound care for one out of two sampled residents (Resident 1). These failures had the potential to increase the risk of infections and cause a delay in wound healing. Findings: 1. A review of the facilities policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 5/20/26, indicated, enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms [an infection that was resistant to many different antibiotics] that employs targeted gown and gloves used during high contact resident care activities. The P&P indicated, residents who had wounds or indwelling (inserted into the body) medical devices (example: Foley/urinary bladder catheter, tube inserted into the bladder and drained urine into a bag) would be placed on EBP precautions. The P&P indicated high contact resident care activities included bathing, dressing, transferring, or providing hygiene (washing face or applying deodorant). A review of Resident 1's admission Record, dated 2/25/26, indicated admission to the facility with the diagnoses of myocardial infarction (a medical emergency also known as a heart attack) and shortness of breath (inability to get enough air into the lungs). Resident 1 was their own responsible party (RP, decision maker) and Family Member (FM) was the alternative RP (made decisions for Resident 1, when they could not make their own). A review Resident 2's admission Record, dated 9/6/24, indicated admission to the facility on 9/6/24 with the diagnoses of hypertension (high blood pressure) and chronic pain. Resident 2 was their own RP. During an observation on 4/15/26 at 10:09 am, EBP precaution signage was observed outside of Resident 1's room. CNA G was observed repositioning Resident 1 from a back lying position to a right-side lying position. CNA G was not wearing a gown. A urinary catheter bag was observed hanging on the side of Resident 1's bed. During an interview on 4/15/26 at 10:26 am, CNA G indicated that residents who had wounds and urinary catheters were placed on EBP and confirmed, Resident 1 had a wound and a urinary catheter. CNA G confirmed the observation and stated, I should have had on a gown. During an observation on 4/15/26 at 10:51 am, EBP signage was observed outside of Resident 2's room. CNA M was observed assisting Resident 2 put on deodorant. CNA M was not wearing a gown or gloves. During an interview on 4/15/26 at 11:02 am, CNA M confirmed the observation and confirmed not wearing a gown or gloves while assisting Resident 2 with applying deodorant to her armpits. CNA M indicated she had just assisted Resident 2 with a shower and was asked what type of PPE was required during a shower and no answer was provided. CNA M stated, I did not wear a gown in the shower, I only handed her the items [described as soap and shampoo] and she washed herself. During an interview on 4/15/26 at 1:30 pm, Director of Staff Development (DSD) confirmed, Residents 1 and 2 were on EBP and stated, gown and gloves should be worn for direct resident care. DSD was described the observations with CNAs G and M and confirmed, CNAs G and M should have been wearing gowns and gloves when providing care to Residents 1 and 2. 2. A review of the facility's P&P titled, Standard Precautions Infection Control, dated 5/20/26, indicated, facility staff would assume all residents were potentially infected. The P&P indicated, during resident care, facility staff should perform hand hygiene (washing hands with soap and water or utilize an alcohol gel-based hand sanitizer) after their hands have been in contact with a resident and before touching other surfaces to avoid spreading potential infection. During an observation on 4/15/26 at 11:15 am, TN C was observed performing a skin assessment and applying zinc oxide cream (thick cream that protected skin from moisture) to Resident 2's buttocks and antifungal cream (a medication cream used to treat (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin infections, for example athlete's feet or yeast infections) under both breasts. TN C pulled her face mask down to her chin and pulled the mask back up to cover her mouth five times and opened Resident 2's door while wearing dirty gloves. TN C did clean the door handle. During an interview on 4/15/26 at 3:15 pm, TN C confirmed the observation and indicated touching her face mask and opening Resident 2's door while wearing dirty gloves was an infection control concern. 3. A review of the facilities P&P titled, Clean Dressing Change, dated 11/1/25, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and or cross contamination. The P&P indicated that a clean field would be utilized on the overbed table (table on wheels where residents ate their meals and personal items were stored) with the needed supplies for wound care, the overbed table would be cleansed, and a disposable pad would be placed on top of the overbed table. During an observation on 4/15/26 at 2:11 pm, TN C was observed preparing to perform Resident 1's wound care. TN C removed a partially eaten lunch tray, papers, and a vase with flowers from Resident 1's overbed table. The overbed table was not cleansed and there was no barrier pad placed on top of the overbed table. Onto the dirty overbed table, TN C placed two clear plastic bags full of gauze (fabric material used to clean wounds), a package of rolled gauze (gauze that was rolled up), a piece of Hyperfix (flexible tape), approximately six syringes (a tube with a plunger) filled with normal saline (salt water), three small bottles of normal saline, four small pink containers of normal saline, a pair of scissors, a small basin (similar to a bowl), a box of gloves, a tube of Santyl (a medication used to remove dead tissue from wounds), and a foam dressing (a padded dressing that was used to cover the wound) that was taken out of its package. TN C moved the overbed table next to Resident 1's bed and placed the box of gloves, directly onto the bed, on top of the bedlinen. When TN C had completed the wound care, TN C placed the box of gloves back into a wire rack that hung on the wall. TN C placed the unused supplies from Resident 1's wound dressing on top of the wound cart that was located outside of Resident 1's room. The unused supplies consisted of four small pink containers of normal saline, two small bottles of normal saline, two partially used plastic bags of gauze, one syringe of normal saline, and a pair of scissors. TN C used chemical cleansing wipes from a white and purple container with the name of micro-kill two to wipe down the unused wound care supplies, brushed her hair off her face, and placed them back into the wound care cart. During an interview on 4/15/26 at 3:15 pm, TN C confirmed the entire observation. TN C was asked to describe infection control measures while performing wound care and no answer was provided. During an interview on 4/15/26 at 4:10 pm, all observations were described to the facility's Infection Preventionist (IP). IP confirmed CNA G should have worn a gown while providing Resident 1 with care. IP confirmed CNA M should have worn a gown and gloves while providing care to Resident 2. IP confirmed TN C should not have touched her mask or Resident 2's door with dirty gloves. IP confirmed that TN C should have cleaned Resident 1's overbed table and placed a disposable barrier pad on it prior to placing clean wound care supplies on it. IP confirmed TN C should not have placed the box of gloves onto Resident 1's bed. IP confirmed TN C should not have cleansed the unused wound care supplies with the micro-kill two wipes and stated, it was not safe and those items are not compatible with use of those wipes.

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	06/02/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record reviews, the facility failed to ensure the environment was safe and sanitary when there was a large piece of plastic bag hanging from the ceiling in the rehabilitation room (where residents exercised and received therapy services) and was draining roof leakage water into a five-gallon bucket that was foul smelling, stagnant (motionless or trapped) water that also contained trash. This had the potential for mold or bacteria to grow which could negatively affect the safety and health status of residents, the public, and facility staff who utilized the physical therapy room.Findings: During an observation on 4/15/26 at 8:59 am, two large tarps (a flexible sheet of waterproof or water-resistant material that was used to protect objects from the weather) were observed covering the roof of the facility. During a concurrent observation and interview on 4/15/26 at 12:32 pm, with Maintenance Director (MD) and Occupational Therapist (OT, healthcare professional that helped residents regain their independence with dressing, eating, or showering), located in the rehabilitation room, a section of the wall that connected to the ceiling was observed to be missing and the inside of the wall was exposed. A large piece of plastic was observed hanging out of the open area. Two zip ties (plastic device that was used to secure something in place) were observed to be tightened around two separate areas of the hanging plastic which gave it a tube-like appearance. Underneath the hanging plastic was a five-gallon white bucket that contained stagnant, foul smelling, dirty water, and trash. To the right of the bucket of water, weighted exercise bags (placed around the resident's ankles or wrists during exercises) hung on the wall. To the left of the bucket of water was a large physical therapy table (used for residents to sit or lay on). A few inches away from the bucket of water was a wooden set of stairs and a scale. A leg rest for a wheelchair and a piece of exercise equipment were up against the bucket of water. MD and OT confirmed the observation, and MD was asked how long the wall/ceiling area had been in disrepair and how long the bucket of water had been there. MD did not provide an answer. OT was asked the same questions and stated, It's been like that for the three weeks I've been here. The inside of the plastic was wet, and MD indicated it was due to the zip ties trapping the water inside of the plastic. MD indicated there was a tarp on the roof, directly over the physical therapy room and the water inside of the plastic was caused by the rainstorms experienced the week prior to the observation. MD was asked what caused the water to drain into the plastic. No answer was provided. On 4/15/26 at 12:46 pm, MD was asked for a policy and procedure (P&P) regarding the facility's physical environment. On 4/15/26 at 1:23 pm, MD provided a copy of the undated Federal Regulation titled Physical Environment. MD indicated this was the P&P. A review of the untitled Federal Regulation titled, Physical Environment, indicated that the facility must be maintained (kept in good repair) to protect the health of the residents, facility staff, and the public. During a concurrent interview and record review on 5/1/26 at 12:10 pm, with MD, a work order titled, ceiling damaged in Rehab, dated 1/6/26 and created by MD, was reviewed. MD confirmed the work order indicated that on 1/6/26, the ceiling in the rehabilitation room had sustained water damage during a rainstorm and a section of the wall had been removed due to the water damage and was leaking. MD confirmed, the plastic hanging from the ceiling and the water bucket were placed there, by MD on 1/6/26.