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	06/18/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that three of three sampled Resident Council members (resident^run group that meet to discuss concerns and offer suggestions about their care) concerns about long call^light wait times were addressed when the facility had not completed a Department Response Form to show any follow^up or actions taken. This failure resulted in care concerns to go unrecognized and violated the residents' rights.Findings: A review of the facility's policy and procedure (P&P) titled, Resident Council Meetings, dated 2026, indicated, the facility's Activity Director (AD) would assist the Resident Council members with concerns by acting as a liaison (go-between person) and sharing their concerns with the facility. The P&P indicated that the facility would act upon concerns and make recommendations and attempt to accommodate the residents. A review of Resident 1's admission Record, dated 1/9/24, indicated admission to the facility on 1/9/24 with the diagnoses of flaccid hemiplegia affecting left dominant side (the left side of the body was weak and unable to move) and chronic pain. Resident 1 was their own responsible party (RP, decision maker). A review of Resident 1's Quarterly Minimum Data Set (MDS, and assessment tool), dated 4/6/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, assessment for memory, attention, and awareness). Resident 1 scored a 15 out of 15 which indicated good memory. A review of Resident 2's admission Record, dated 3/16/26, indicated admission to the facility on 3/16/26 with the diagnoses of a broken right hip that did not require surgical intervention and difficulty in walking. Resident 2 was their own RP. A review of Resident 2's Quarterly MDS, dated [DATE], indicated that Resident 2 had a BIMS score of 14 out of 15 which indicated good memory. A review of Resident 3's admission Record, dated 9/11/25, indicated admission to the facility on 9/11/15 with the diagnoses of difficulty in walking and hypertension (high blood pressure). Resident 3, with the help of a family member, acted as the RP. A review of Resident 3's Quarterly MDS, dated [DATE], indicated that Resident 3 had a BIMS of 13 out of 15 which indicated good memory. During an interview on 5/19/26 at 10:20 a.m., Resident 1 indicated that on the last two Saturday evenings (5/9/26 and 5/16/26), when Resident 1 utilized the call light for assistance to use the bathroom, Resident 1 experienced long call^light wait times. Resident 1 indicated waiting up to two hours for facility staff to respond to the call light, and after being assisted to the bathroom, it took 40 minutes for staff to respond to the bathroom call light. Resident 1 confirmed this concern was voiced at the Resident Council meetings. Resident 1 stated, It makes me angry. During an interview on 5/19/26 at 10:24 a.m., Resident 2 indicated that when staff were delivering meal trays, it was not uncommon for Resident 2 to experience call^light wait times up to an hour. Resident 2 confirmed this concern was discussed at the Resident Council meetings. Resident 2 stated, I worry and feel ignored when they don't answer my call light. During an interview on 5/19/26 at 3:04 p.m., Resident 3 indicated utilizing her call light for her roommates. Resident 3 said sometimes her roommates needed assistance with repositioning and could not find their call light and Resident 3 utilized her call light for them. Resident 3 confirmed experiencing 30^minute call^light wait times and stated this was discussed many times at the Resident Council meetings. During a concurrent interview and record review on 5/19/26 at 3:10 p.m., with the AD, Resident Council Minutes [meeting notes] dated 2/23/26 through 4/21/26 were (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed. The AD confirmed the Resident Council meeting notes dated 2/23/26, 3/26/26, and 4/21/26 indicated that the Resident Council members had stated that call lights were not being answered in a timely manner. The AD confirmed there was no, Department Response Form completed regarding the concerns the Resident Council brought up and stated, I was not here for the Resident Council meeting held on 2/23/26. When asked if there was a reason the Department Response Form was not being completed, the AD indicated it was due to the AD's lack of knowledge regarding the use of the Department Response Form. During a concurrent interview and record review on 6/18/26 at 8:41 a.m., with the Administrator (Admin), a blank copy of the Department Response Form was reviewed. The Admin confirmed the Department Response Form included the resident's concerns, the facility's response to the concerns, and any followˆup regarding a solution. The Admin confirmed the AD was responsible for completing the Department Response Form and stated, follow up should be done.