

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review, the facility failed to provide Physical Therapy (PT) in a timely manner to meet the needs of one of 19 sampled residents (Resident 31) when needed therapy services were delayed due to an insurance transfer from another facility.</p> <p>This failure caused Resident 31 to feel angry, sad, and had the potential for a functional decline.</p> <p>Findings:</p> <p>The facility's policy revised 2025, titled, Resident Rights, indicated all residents will be treated equally regardless of age, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expression. The facility will ensure that all direct care staff and individual staff members, including contractors and volunteers, are educated on the rights of the residents and responsibility of the facility to properly care for its residents.</p> <p>The facility's policy revised 2024, titled, Therapy Evaluation, indicated the licensed therapist will perform an initial resident evaluation upon physician referral and any re-evaluation where indicated.</p> <p>During a review of Resident 31's record titled, admission Record, indicated Resident 31 was admitted the facility on 12/1/23 with diagnoses that included hemiplegia and hemiparesis following a Cerebral Vascular Accident, (CVA or commonly called stroke with weakness and inability to move one side of the body), Covid 19 (a serious respiratory infection), diabetes (too much sugar in the blood), high blood pressure, Major Depressive Disorder (persistent feelings of sadness and loss of interest in activities), Anxiety (feelings of worry, nervousness, and unease), muscle weakness (lack of strength in the muscles making it harder to move and do normal activities), and chronic pain (long lasting period of pain for more than three months).</p> <p>A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 3/8/25, indicated that Resident 31 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 31 required substantial/maximum assistance with all transfers out of bed, showers and dressing.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a document dated 1/11/24, titled, PT evaluation and plan of Treatment, indicated Resident 31 requires skilled PT services to assess functional abilities, enhance rehab potential, evaluate the need for assistive device [such as a walker or wheelchair] facilitate independence with all functional mobility, improve dynamic balance, increase functional activity tolerance, increase LE (lower extremities) range of motion and strength, minimize falls, and safety awareness.</p> <p>During an interview on 6/16/25 at 3:30 pm, Resident 31 stated, I am so upset about PT, I have only been down to the PT room one time since I was admitted . They tell me I don't have insurance, and no one will help me get it straightened out since I was transferred over 18 months ago from another facility.</p> <p>During an interview on 6/17/25 at 8:30 am, the Business Office Manager (BOM) confirmed Resident 31 needed to go to the social security administration and another office to transfer her insurance to this county, and it was true she was not receiving therapy because of the insurance problems.</p> <p>During a follow up interview on 6/17/25 at 1:30 pm, the BOM stated, I am going to meet [Resident 31] for two appointments next week, one on Wednesday and one on Thursday. We will just wait in line, and we don't need an appointment, but I will stay with her and get all of this insurance straightened out. I don't usually work in this facility, I work in a sister facility, but they approved me to help to get this resolved as soon as possible. It has been over 18 months since she was admitted .</p> <p>During an interview on 6/17/25 at 2:40 pm, the Director of Nursing (DON) and the administrator (Admin) confirmed Resident 31 should have already had her insurance changed to this local county many months ago, but it will be resolved next week.</p> <p>During a follow up interview on 6/18/25 at 10:30 am, the DON and Admin confirmed not helping Resident 31 with needed PT services is a violation of residents' rights.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on interview, and record review, the facility failed to ensure one of 19 sampled residents (Resident 21) was treated with dignity and respect when Registered Nurse (RN) G was rude during direct resident care.</p> <p>This failure had the potential to result in emotional stress, embarrassment, feelings of neglect, increased anxiety, and the potential for negative clinical outcomes.</p> <p>Findings:</p> <p>The facility's policy revised 8/2024, titled, Promoting/Maintaining Resident Dignity, indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</p> <p>The facility's policy revised 2025, titled, Resident Rights, indicated all residents will be treated equally regardless of age, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expression. The facility will ensure that all direct care staff and individual staff members, including contractors and volunteers, are educated on the rights of the residents and responsibility of the facility to properly care for its residents.</p> <p>During a review of Resident 21's record titled, admission Record, indicated Resident 21 was admitted the facility on 8/23/24 with diagnoses that included high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a progressive lung disease), local infection of the skin (when bacteria gets into a small limited spot, causing inflammation and infection), (Bi-polar Disorder (a mental health condition that causes extreme mood swings), Anxiety (feelings of worry, nervousness, and unease), Borderline Personality Disorder (BPD, mental health condition that cause intense emotions, unstable relationships, and difficulty managing their feelings), Major Depressive Disorder (persistent feelings of sadness and loss of interest in activities), and Post Traumatic Stress Disorder (a general term used to describe a disorder that develops who have experienced a shocking, scary, or traumatic event).</p> <p>A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 3/1/25, indicated that Resident 21 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason), and could verbalize needs. This MDS also indicated Resident 21 required substantial/maximum assistance with all transfers out of bed, bathing and dressing.</p> <p>A review of a care plan dated 9/12/24 indicated Resident 21 was dependent on staff for activities for daily living (ADLs-bathing, dressing, transfers, toileting and hygiene) related to resident 21 has had a decline in self-care and functional mobility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/16/25 at 11:40 am, Licensed Nurse (LN) A stated, [Resident 21] told me [RN G] was rude to her and she had reported it to the Director of Nursing [DON], they had a meeting in her room about several issues including [RN G].</p> <p>During an interview on 6/16/25 at 1:13 pm, DON confirmed she had a meeting to go over many concerns with Resident 21 and the Ombudsman was present. DON stated, I do confirm this incident of [RN G] being rude would be considered a violation of Resident 21's resident rights and dignity.</p> <p>During an interview on 6/17/25 at 9:40 am, Resident 21 stated, [RN G] was rude to me, and we both argued about the time to do my treatment to my left toe. I argued back. She came back in my room that evening and it seemed to be an apology. She was too nice, but I still never want to see her in my room again, I told the other staff I was going to report [RN G] for being rude.</p> <p>During an interview on 6/18/25 at 8:45 am, the Administrator confirmed RN G would not be back to the facility and agreed Resident 21's dignity and resident rights were violated when RN G was rude during direct resident care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents sampled for Abuse (Resident 7), was free from verbal abuse when Certified Nurse Assistant (CNA) I verbally abused Resident 7.</p> <p>This failure had the potential to negatively impact Resident 7's sense of security, emotional, and psychological well-being.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, and Exploitation, no date, the P&P indicated, Abuse is defined as, the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse, Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>A review of Resident 7's clinical record indicated she was admitted to the facility on [DATE] with diagnoses that included Paralytic syndrome (inability to move or fell parts of the body), Quadriplegia (loss of function in all arms and legs), difficulty swallowing, irregular heart rate, and contracture both arms and legs.</p> <p>A review of Resident 7's most recent Minimum Data Set (MDS, a standardized resident assessment) dated 2/1/25, indicated, Resident 7's was cognitively intact (able to reason and think).</p> <p>During an interview on 6/16/25 at 11:30 pm, with Resident 7, Resident 7 stated, a CNA yelled at me when they were transferring me to bed. Whenever I get transferred to my bed or chair, they use a Hoyer lift (a mechanical device that lifts individuals with limited mobility from one place to another) I get scared and when that girl stopped me in mid-air and started yelling at me, I was very scared.</p> <p>During an interview on 6/16/25 at 3:14 pm, with CNA D, CNA D indicated that she and CNA I were in Resident 7's room getting her back to bed. When Resident 7 was being transferred she was a little afraid and upset. CNA I stopped her mid transfer in the air and started yelling at her. CNA D confirmed that CNA I told Resident 7, This is why no one likes to work with you, and no one likes to give you care. CNA D indicated that she told CNA I to leave Resident 7's room.</p> <p>During an interview on 6/16/25 at 4:00 pm, with CNA C, CNA C indicated he heard yelling from Resident 7's room down the hall. CNA C stated, I couldn't hear what was being said but there was definitely yelling. I knocked on the door and asked if they needed help. CNA C confirmed that CNA D had told CNA I to get out of Resident 7's room. CNA D then asked CNA C to stay and help.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's, Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 3/24/25, the SOC 341 indicated CNA I stated, I know I was out of line and shouldn't have gotten so upset with Resident 7. I did raise my voice, and I know it, Resident 7 just got me really upset. Resident 7 stated, [CNA I] did raise her voice and made her feel like she was not wanted here.</p> <p>During a review of CNA 1's employee file dated 3/27/25, indicated that CNA I showed misconduct, poor performance and failed to maintain acceptable standards of respect for residents, visitors, and employees.</p> <p>During a review of Resident 7's Progress Note type, Alert Note, dated 3/24/25 at 4:45 pm, the Alert Note indicated, Resident 7, reports feeling hurt about the experience and the things that were said.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the Interdisciplinary Team (IDT, the facility managers who meet to discuss the care needs of the residents) developed care plans for one of nineteen sampled residents (Resident 23), when there was no care plan developed for pain management or oxygen use for Resident 23.</p> <p>This failure had the potential for staff to not be fully informed on Resident 23's needs regarding pain control and respiratory care.</p> <p>Findings:</p> <p>During a review of the facility policy titled, Comprehensive Care Plans, undated, indicated, that the facility will develop and implement a comprehensive person-centered care plan for each resident. The care plan will be revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS, an assessment tool) assessment.</p> <p>During a review of record titled, admission Record, with an admission date of 5/29/25, indicated that Resident 23 was admitted with diagnoses that included chronic pain and syncope (fainting spells).</p> <p>During a review of Resident 23's Mimimum Data Set (MDS, an assessment tool) dated 6/3/25, Section C - Cognitive Patterns, indicated Resident 23 had a Brief Interview for Mental Status (BIMS, an assessment of memory and decision making skills) score of 8 out of 15, which indicated some memory and decision making problems.</p> <p>During a concurrent observation and interview on 6/16/25 at 4 pm, with Licensed Nurse (LN) A at Resident 23's bedside, Resident 23 indicated she had chronic pain and was using oxygen. LN A confirmed that Resident 23 used pain medication regularly and oxygen.</p> <p>A review of Resident 23's, Clinical Physician Orders, dated May and June 2025, indicated that Resident 23 had physician ordered Oxygen at 2 liters per minute (LPM) by way of nasal canula (a tube in the nose) every shift that began on 6/04/25, and Hydrocodone-Acetaminophen (a narcotic pain medication) 10-325 milligrams (mg, a unit of measure) tablet four times a day for pain that began on 5/29/25.</p> <p>A review of Resident 23's Care Plans reflected that no care plans had been developed which addressed her oxygen use or pain management.</p> <p>During a concurrent record review and interview on 6/18/25 at 2:24 pm, with the Director of Nursing (DON), the DON confirmed that there had been no care plans developed for Resident 23's oxygen use or pain management, and those care plans should have been developed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care to residents in accordance with professional standards of practice for four of 19 sampled residents (Resident 17, 50, 21, and 23) when:</p> <ol style="list-style-type: none"> 1. Resident 17 had continuous oxygen (O2) administered with no Medical Doctor (MD) order. 2. Resident 50 did not have medication administered as directed by MD order. 3. Resident 50 did not have O2 tubing changed weekly and labeled per resident centered care plan, nor professional standard of practice. 4. Resident 21's treatment was not completed as directed by MD order. 5. Resident 23 did not have O2 tubing labeled and dated per resident centered care plan, nor professional standard of practice. <p>These failures of not following or obtaining MD orders, nor adhering to medical professional standards of practice had the potential to result in profound physical health complications, increased mental health problems, and general decline.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated 2025 Revision, the medication orders policy indicated, Medications should be administered only upon the signed order of a person lawfully authorized to prescribe.</p> <p>During a review of the facility's P&P titled, Oxygen Administration, dated 2025, the oxygen administration P&P indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, (and) the comprehensive person-centered care plans .Oxygen is administered under orders of a physician .Staff shall perform .infection control measures include(ing): Change oxygen tubing .weekly and as needed .</p> <ol style="list-style-type: none"> 1. A review of Resident 17's medical record indicated that Resident 17 was admitted on [DATE] with diagnoses that included, Chronic Obstructive Pulmonary Disease (COPD, inflammatory lung diseases that block airflow and make it difficult to breathe), Chronic Diastolic Congestive Heart Failure (CHF, a condition where the heart muscle, specifically the left ventricle, becomes stiff and doesn't fill properly during the relax phase of the heartbeat leading to inadequate filling of blood between heartbeats, and inadequate perfusion of tissue), and Chronic Kidney Disease (CKD, Loss of kidney function leading to a dangerous buildup of fluid, electrolytes, and waste). Resident 17 is deemed cognitively competent, acted as their own representative (RP) and made their own medical decisions. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/16/25 at 1:00 pm, Resident 17 was in their room laying on the bed with an elevated head of the bed (HOB) wearing 02. The 02 was being administered via oxygen concentrator (medical device that separates nitrogen from the air around to provide oxygen for breathing) connected to long thin, vinyl tubing nasal cannula (nc, oxygen delivery method inserted into the nose). The 02 was being administered at 4 liters Per Minute (LPM, measurement for administration of 02).</p> <p>During an interview on 6/17/25 at 11:00 am, with Registered Nurse (RN) B in the hall outside of Resident 17's room, RN B indicated Resident 17 should always wear 02, and is always very short of breath (SOB). RN B stated. It's been this way since I have been here. We try to ensure the 02 stays on because the resident really needs it.</p> <p>During a concurrent interview and record review on 6/17/25 at 3:00 pm, with Director of Nursing (DON) in the DON's office Resident 17's, Order Summary Report, Medication Administration Report (MAR), and Care Plan Report, all dated June 2025, were reviewed. The Order Summary Report did not indicate that an MD order was written for Resident 17 to have oxygen. Resident 17's MAR did not indicate that 02 was being administered and was not documented. The Care Plan Report did indicate that Resident 17 had 02 therapy ordered at 4 L continuous flow with interventions including directives to follow MD orders. The DON confirmed Resident 17 is currently using 02 without an order to do so by the MD. The DON confirmed per facility policy, professional standards of practice, and expectations, that all medications, including 02, required an MD order.</p> <p>2. A review of Resident 50's medical record indicated that Resident 50 was admitted on [DATE] with diagnoses that included, Osteomyelitis (inflammation of bone caused by infection), Pressure Ulcer of Sacral Region (low back), Stage 4 (a severe, full thickness skin and tissue loss that extends down to the bone, muscle, or tendon), Polyneuropathy (peripheral nerve damage), and Bipolar Disorder (Mental health condition causing extreme mood swings from depression to mania, affecting activity, judgement, thinking, and behavior). Resident 50 was deemed cognitively competent, acted as their own RP and made their own medical decisions.</p> <p>During an interview on 6/16/25 at 12:30 pm, with Resident 50 in the smoking area, Resident 50 stated, I did not receive my Lyrica [a controlled substance for nerve pain] for 5 consecutive days in May. I have been informed that Lyrica is not a medication you should abruptly stop taking. I felt weird after I wasn't given my medication. I notified the staff immediately, but still did not get it for 5 days. I do get it now.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/18/25 at 3:30 pm, with DON and RN B in the DON's office, the MAR, Order Summary Report, and Care Plan Report, dated May and June 2025, for Resident 50 were reviewed. The MAR indicated that on 5/23/25 Lyrica was held for both doses, 5/24/25 Lyrica was held for both doses, 5/25/25 Lyrica was held for both doses, 5/26/25 Lyrica was held for both doses, and on 5/27/25 Lyrica was held for the morning dose. In the MAR indicated that the Lyrica was not given due to the pharmacy not delivering and on hold by the doctor. The Order Summary Report indicated that there was an order for Lyrica 150 milligrams (mg, measurement for dosage) to be administered twice daily (am and pm). There was no MD order to hold the Lyrica at any time. The person-centered care plan indicated Resident 50 took Lyrica for polyneuropathy and the medication is to be administered per MD orders. RN B confirmed that the pharmacy had not delivered Resident 17's Lyrica when it was ordered. RN B confirmed that the Pharmacy was notified that Resident 17's Lyrica was not delivered, but no one had followed up and the Lyrica was obtained late on 5/27/25. RN B confirmed that Resident 17's doctor did not put the Lyrica on hold at any time. DON confirmed, per policy, professional standards of practice, and expectations, all medications require an MD order. DON indicated that if a medication was not delivered by the Pharmacy, even after the reminder fax, nursing must follow-up to ensure the medication is obtained.</p> <p>3. A review of Resident 17's medical record indicated that Resident 17 was admitted on [DATE] with diagnoses that included, COPD,CHF, and CKD. Resident 17 was deemed cognitively competent, acted as their own RP and made their own medical decisions.</p> <p>During an observation on 6/16/25 at 1:00 pm, Resident 17 was in his room in bed wearing O2. The O2 was being administered via oxygen concentrator and nasal cannula. The O2 tubing had a label indicating it was changed on 6/4/25 at 01:12 am, twelve days ago.</p> <p>During a concurrent interview and record review on 6/17/25 at 3:00 pm, with DON in the DON office, the facility's P&P titled, Oxygen Administration, dated 2025, and Care Plan Records, dated June 2025, were reviewed. The person-centered care plan indicated under interventions, Change disposable oxygen tubing . weekly. DON confirmed tubing must be labeled with the date, time, and nurse's name each time the O2 tubing was changed and that was expected to be done weekly. DON confirmed that Resident 17's O2 tubing had not been changed for 12 days.</p> <p>4. A review of the facility's policy revised 2024, titled, Wound Treatment Management, indicated it is the facility's policy to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with the physician orders, including the cleaning method, type of dressing, and frequency of dressing changes. The facility will follow specific physician orders for providing wound care.</p> <p>During a review of Resident 21's record titled, admission Record, indicated Resident 21 was admitted the facility on 8/23/24 with diagnoses that included high blood pressure, Chronic Obstructive Pulmonary Disease (COPD, a progressive lung disease), local infection of the skin (when bacteria gets into a small limited spot, causing inflammation and infection), Bi-polar Disorder (a mental health condition that causes extreme mood swings), Anxiety (feelings of worry, nervousness, and unease), Borderline Personality Disorder (BPD, mental health condition that causes intense emotions, unstable relationships, and difficulty managing feelings), Major Depressive Disorder (persistent feelings of sadness and loss of interest in activities), Post Traumatic Stress Disorder (a general term used to describe a disorder that develops who have experienced a shocking, scary, or traumatic event).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 3/1/25, indicated that Resident 21 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason), and could verbalize needs. This MDS also indicated Resident 21 required substantial/maximum assistance with all transfers out of bed, bathing and dressing.</p> <p>A review of a document dated 6/3/25, titled, Active Orders, indicated to soak Resident 21's left big toe with Epsom salt (a mixture of magnesium sulfate to help with inflammation and pain), for 15-20 minutes, pat dry, apply TAO (triple antibiotic ointment), gauze and coband (a stretchy type of tape to secure) every day shift for wound care.</p> <p>During an interview on 6/16/25 at 11:06 am, Social Services confirmed Resident 21 reported to her that RN G used table salt instead of Epsom's salt to soak her toe in and she reported this to the DON.</p> <p>During an interview on 6/16/25 at 1:13 pm, the DON confirmed the physician orders were not followed for Resident 21's treatment for the left great toe. DON stated, [RN G] was taken off the schedule for not following professional standards of care, and she will not be back. [RN G] did use regular table salt instead of Epsom salt for the treatment ordered for [Resident 21].</p> <p>5. During a review of Resident 23's admission Record indicated that Resident 23 was admitted on [DATE] with diagnoses that included chronic pain and syncope (temporary loss of consciousness).</p> <p>A review of Resident 23's MDS dated [DATE], indicated a BIMS score of 8, which indicated a moderate problem with memory and decision making.</p> <p>During an observation on 6/16/25 at 11:00 am, in Resident 23's room, undated oxygen tubing was observed lying on Resident 23's bed, attached to the oxygen concentrator which was running. Resident 23 was observed sitting in a wheelchair in the facility lobby using oxygen from a portable tank with tubing that was also undated.</p> <p>During a concurrent observation and interview on 6/16/25 at 4:00 pm, with LN A at Resident 23's bedside, Resident 23 was witnessed using oxygen tubing that was not labeled or dated. LN A confirmed the oxygen tubing was not dated. LN A stated that oxygen tubing is not always labeled, that it is changed every Sunday regardless of whether or not it had been labeled and dated.</p> <p>During a review of Resident 23's, Clinical Physician Orders indicated a physician's order for Oxygen at 2 LPM by nasal canula every shift beginning on 6/04/25.</p> <p>During an interview with LN E on 6/18/25 at 11:29 am, LN E indicated that oxygen tubing was changed by the night shift every Tuesday.</p> <p>During an interview with DON on 6/18/25 2:24 pm, DON confirmed that all oxygen tubing should be labeled with the date, changed weekly, and be included in residents care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview and nursing schedule review, the facility failed to ensure that there was a Registered Nurse (RN) on duty 8 hours per day, 7 days a week.</p> <p>This failure had the potential to adversely affect oversight and direction regarding resident's quality of care and quality of life directly impacting overall health and well-being of the residents.</p> <p>Findings:</p> <p>A review of the Payroll Based Journal (PBJ, an electronic system for facilities to submit staffing information), for Fiscal Year Quarter 2 / 2024: (January 1-March 31), indicated the facility had no registered nurse (RN) on duty for:</p> <p>1/13/24 Saturday (Sa), 1/27/24 (Sa), 1/28/24 Sunday (Su), 2/3/24 (Sa), 2/4/24 (Su), and 3/17/24 (Su).</p> <p>During an interview on 6/24/25 at 10:11 am, the Interim Director of Nursing (IDON) confirmed, the facility did not have a RN for the above stated time periods.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were met in the kitchen when: the blender was not air dried, two of four non-stick coated frying pans did not have a cleanable surface, and the hood over the stove had greasy, black debris on it and was not clean.</p> <p>These failures had the potential to place the 52 residents who received food prepared in the facility kitchen at risk for foodborne illness.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Kitchen Hood Inspection and Cleaning, undated with a copyright of 2025, indicated, the kitchen hood exhaust system will be properly cleaned and maintained in order to support the kitchen hood fire suppression system to foster a safe and healthful environment .</p> <p>A record review of the, Diet Order Tally Report on 6/17/25, indicated there were 15 residents with mechanically soft diets (chopped food), four with puree diets (ground or liquid texture), and 33 residents on regular diets, for a total of 52 residents that the kitchen prepared food for.</p> <p>During an observation in the facility kitchen on 6/16/25 at 12:50 pm, a blender was stored wet with the lid on the blender.</p> <p>During an interview with the Certified Dietary Manager (CDM) on 6/16/25 at 12:55 pm, the CDM confirmed the blender had not been air dried.</p> <p>According to USDA Food Code 2022, Section 4-901.11, (A) After cleaning and sanitizing, equipment and utensils must be air-dried or used after adequate draining.</p> <p>During an observation in the facility kitchen 6/16/25 at 12:51 pm, two nonstick pans were observed with excessively worn cooking surfaces.</p> <p>During an interview with CDM on 6/16/25 at 12:57 pm, the CDM confirmed the two nonstick pans were excessively worn and would be discarded.</p> <p>According to USDA Food Code 2022, Section 4-202.11, multiuse food-contact surfaces shall be (1) smooth and (2) free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections.</p> <p>During an observation in the facility kitchen 6/16/25 at 12:53 pm, the inside of the exhaust hood over the stove was wiped with a white paper towel underneath it. The inside of the exhaust hood was not clean with a greasy, black debris.</p> <p>According to the, Dietary Department Cleaning Schedule and Check List, with a beginning date of 6/9/25 and ending date of 6/15/25, the section on Hoods had a signature in the Sunday box, indicating the hood was cleaned on Sunday, 6/15/25. It indicated the pm cook is in charge of cleaning the hood and signing the log.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the CDM on 6/16/25 at 12:58 pm, the CDM confirmed the hood over the stove was not clean.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and facility document review, the facility failed to ensure essential equipment was maintained in safe operating condition when the walk-in freezer had not kept frozen food frozen and there was excessive ice build-up on the freezer floor.</p> <p>These failures had the potential for the freezer to not function in the way it was intended which could lead to contamination of food, and in turn food-borne illnesses for the 52 residents who received food prepared by the kitchen. Excessive ice build up could pose a safety hazard and accidents for vendors and employees who enter the walk-in freezer.</p> <p>Findings:</p> <p>According to the USDA Food Code 2022 Section 4-501.11, Equipment shall be maintained in good repair and proper adjustment.</p> <p>On 6/16/25 at 10:25 am, an observation of the walk-in freezer and concurrent interview was conducted with the Certified Dietary Manager (CDM). According to the internal thermometer located in the walk-in freezer, the internal temperature of the freezer was 20 degrees Fahrenheit (F). A five-gallon container of strawberry ice cream stored on the freezer shelf was completely melted. The CDM confirmed the finding and stated the ice cream would be discarded. The floor of the freezer had a black floor mat that was covered in ice and frozen ice approximately six by six inches in the shape of a ball was on the freezer floor next to the floor mat. The CDM indicated the freezer temperature problem had been repaired last year and there was a plan to repair the freezer again.</p> <p>On 6/16/25 at 12:55 pm, an observation of the walk-in freezer was conducted. According to the internal thermometer located in the walk-in freezer, the temperature was 34 degrees F. Using the surveyor thermometer, the internal temperature of the walk -in freezer was 34.3 degrees F. One box of cinnamon bread dough and one box of individual raspberry sorbet were thawed and not frozen solid.</p> <p>On 6/16/25 at 3:35 pm, an observation of the walk-in freezer and concurrent interview was conducted with the Director of Maintenance (DM). According to the internal thermometer located in the walk-in freezer, the internal temperature of the walk-in freezer was 40 degrees F. The DM indicated the freezer had a defrost cycle four times a day for 15 minutes each cycle. The DM stated when the freezer was in the defrost cycle, water dripped on the floor, froze, and created large amounts of ice. The DM further stated the wall and roof of the freezer had dry rot (rotted wood), and there was a project plan to replace the roof and add insulation. The DM indicated he would contact an outside company to come inspect the freezer.</p> <p>During a concurrent interview and observation with the CDM on 6/17/25 at 11:05 am, the outside walls of the walk-in freezer showed exposed insulation, wood framing, and the outside wall was missing on one side. All freezer hardware was exposed to the outside of facility. The CDM confirmed these findings.</p> <p>On 6/17/25 at 3:25 pm, an interview was conducted with the Director of Nursing (DON). The DON confirmed the walk-in freezer should be in working order with temperatures at or below 0 (zero) degrees Fahrenheit and all foods should be frozen solid.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Shasta View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on observation, interview, and document review, the facility failed to provide 80 square feet per resident per room in 12 of 22 resident rooms, as required by regulation (Rooms 1, 2, 3, 4, 5, 17, 18, 19, 20, 21, 22, and 23).</p> <p>This failure had the potential to result in inadequate space for care and services provided as well as potential to negatively affect resident physical and emotional comfort and feelings of overall well-being.</p> <p>Findings:</p> <p>During the entrance conference on 6/16/25 at 10:00 am, a previous copy of the waiver for reduced bedroom sizes granted to the facility by the Centers for Medicare & Medicaid services (CMS) was discussed and reviewed with the Administrator (Admin). There has been no physical expansion for rooms since the last survey.</p> <p>During a review of resident census information provided 6/16/25, titled, Resident List Report, and a bed roster list, indicated rooms 1, 2, 3, 4, 5, 17, 18, 19, 20, 21 and 23 had determined capacity with beds present to hold three residents per room.</p> <p>During concurrent observation and interview throughout the survey, it was observed that residents in rooms 1, 2, 3, 4, 5, 17, 18, 19, 20, 21 and 23 had a reasonable amount of privacy with sufficient room to provide nursing care and services. The residents had adequate space for their personal affects, and limited furniture without overcrowding. There were no complaints regarding room size from the residents in these rooms. The State Agency recommends continuance of the room size waiver.</p>		