STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055807	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Estates	445 Park Street Weed, CA 96094

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure safe discharge for one of two residents sampled (Resident 1), when Resident 1 chose to leave the facility Against Medical Advice, (AMA, when the physician does not agree with the resident leaving the facility because of their medical condition) and the facility failed to ensure;1. There was a physician's order to discharge Resident 1 AMA.2. Discussion and documentation was done with Resident 1 of alternatives to discharging AMA to the location to which Resident 1 discharged .3. An Against Medical Advice form (A form that a resident signs acknowledging understanding of the consequences for leaving the facility AMA), was not offered to Resident 1.4. A facility investigation was done and an Adult Protective Services (A government service to protect vulnerable individuals in the community from abuse, neglect and exploitation) report filed.These combined failures resulted in Resident 1 not being informed by the facility of the consequences of leaving the facility AMA and Resident 1 was admitted to the acute care hospital within two days after leaving the facility, with an infection. Findings:1.Review of a facility policy titled, Discharging a Resident without a Physician's Approval, revised October 2022 indicated, A physician's order is obtained for discharges, unless a resident or representative is discharging himself or herself against medical advice, 3. If the resident or representative (sponsor) requests discharge without the approval of the attending physician, the resident and/or representative (sponsor) will be asked to sign a release of responsibility form. 4. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will: a. discuss with the resident, (and/or his or her representative, if applicable) and document the implication and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location; b. document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed; c. document that despite being offered other options that could meet the resident's needs, the resident refused those more appropriate settings; d. determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge. Review of the admission record for Resident 1, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included a sacrum fracture (a break in the large triangular bone at the base of the spine).Review of Resident 1's admission MDS (Minimum Data Set- a federally mandated assessment tool that measures the health status in nursing home residents), dated 7/11/25, completed by Minimum Data Set/Registered Nurse (MDS/RN), section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS), score of 12 out of 15 which indicated that Resident 1 had good memory and decision making skills. Review of Resident 1's record titled, Physician Order Report: 7/2/25 to 8/20/25 indicated that there was no physician's order discharging (the official directive from a doctor to a healthcare facility that a patient no longer requires inpatient care and can safely transition to another level of care, such as home) Resident 1.2.Review of Resident 1's progress note dated 8/11/25 at 7:29 p.m., written by the Wound Care Nurse/Registered Nurse (WCN/RN, a registered nurse with specialized training and certification in wound care), the WCN/RN indicated that upon preparing for Resident 1's unplanned AMA she educated the family about Resident 1's extensive treatment for a Stage 4 (Bedsore, a severe form of skin damage, that involves full-thickness tissue loss that exposes muscle and bone), care needs that Resident 1 had developed while in the facility. There was no documentation of discussion of the implications and/or risks of being discharged to a location that was not equipped to meet her needs or an attempt to ascertain why the resident chose that location. There was no documentation of discussion on more suitable options of locations that were equipped to meet the needs of Resident 1. There was no documentation completed that despite being offered other options that could meet the resident's needs, the resident refused those more appropriate settings. Review of Resident 1's progress note dated 8/11/25 at 4:25 p.m. written by Registered Nurse (RN) B indicated that Resident 1's family arrived at the facility at 11:00 a.m., and requested to take Resident 1 home and that Resident 1 left the facility at 2:15 p.m. with her family.Review of Resident 1's, Transition of Care/Discharge Summary dated 8/11/25 indicated, Discharge Destination: Resident to return to independent living with spouse support after acute stay. This statement was incorrect, however, because Resident 1's home was in a nearby town, but she left the facility with her family to a city that was three hours away.During an interview on 8/22/25 at 11:52 a.m., with Family Member (FM) 2, FM 2 indicated that she was angry about

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the care plan (a document that outlines a patient's health care needs and the actions and interventions required to address them), was revised and updated when one of two sampled residents (Resident 1), had a pressure injury (PI, a bedsore) that worsened and the care plan had not reflected this.This failure resulted in no identified problem, goals or interventions to promote the healing of Resident 1's PI to her sacrum (the large triangular bone at the base of the spine), and inconsistencies and delayed treatments of Resident 1's PI, which had a negative impact on her clinical status.Findings:Review of a facility policy titled, Goals and Objectives, Care Plans revised April 2009, indicated, 5. Goals and objectives are reviewed and/or revised: a. when there has been a significant change in the resident's condition.Review of the National Pressure Injury Advisory Panel's (a nationally recognized professional resource for the staging and treatment of pressure injuries a global driver of quality improvement and patient safety in healthcare) website document titled, NPIAP Pressure Injury and Stages, at https://npiap.com, dated September 2016 indicated;-Stage 1 pressure injury: non-blanchable (skin redness or discoloration that does not fade or turn white when pressure is applied) erythema (reddening of the skin), which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes.-Stage 2 pressure injury: partial-thickness skin loss with exposed dermis (the middle, living layer of the skin, located between the outermost epidermis and the innermost hypodermis).Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. 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 (thick stringy yellow infected tissue or eschar (black dead tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. -Stage 3 pressure injury: full-thickness loss of skin, in which adipose (fat) is visible in the injury and granulation tissue and epibole (rolled wound edges) are often present. Slough (dead tissue, usually moist and stringy) and/or eschar (dead tissue that is hard or soft) may be visible. If slough or eschar obscures the extent of tissue loss this is and Unstageable Pressure Injury.-Stage 4 pressure injury: full-thickness loss of skin and tissue with exposed Fascia (a thin fibrous connective tissue that surrounds and supports all muscles, organs, and other structures in the body), muscle, tendon (a tough, fibrous cord-like tissue that connects muscles to bone) ligament (a tough, fibrous band of connective tissue that connects two bones together, providing stability and support to joints), cartilage (a smooth, elastic connective tissue that provides support and protection to joints, bones, and other tissues in the body) in the injury. Slough or eschar may be visible. Epibole, undermining (the destruction of tissue or injury extending under the skin edges so that the pressure injury is larger at its base than at the skin surface) and/or tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) often occur.Review of the admission record for Resident 1 indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including sacrum fracture (a break in the large triangular bone at the base of the spine), and was not admitted with any PIs.Review of Resident 1's admission MDS (Minimum Data Set- a federally mandated assessment tool that measures the health status in nursing home residents), dated 7/11/25, completed by Minimum Data Set/Registered Nurse (MDS/RN), section C indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 out of 15 indicating she was cognitively intact. Section M indicated no pressure injuries.A comparison review of Resident 1's records titled, Wound Management Detail Report dated 7/24/25 to 8/11/25, and Care Plan History dated 7/30/25 reflected that: On 7/24/25 Resident 1 had a Stage 2 PI on her sacrum and the care plan was not updated until 7/30/25, a week later and the PI had already worsened to an Unstageable PI.On 8/3/25 Resident 1's Unstageable PI worsened to a Stage 4 and showed signs of infection with eschar (dead black tissue) and slough (stringy thick yellow dead tissue, which is a breeding ground for bacteria and prevents wounds from healing), and there were no revisions or updates to her care plan.On 8/11/25 Resident 1's PI worsened to a Stage 4, and and no revisions or updates were made to her care plan.During a concurrent interview and record review on 8/22/25 at 10:33 a.m., with Wound Care Nurse/Registered Nurse (WCN/RN), the WCN/RN confirmed Resident 1's skin integrity care plans had not been updated since 7/30/25, and had not reflected her current status, treatments, and interventions. During an interview by email with the Director of Nursing (DON) on 8/29/25 11:12 a.m., the DON confirmed

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure that a resident who entered the facility without a pressure injury (PI, a bedsore) did not develop a PI, for one of two residents sampled for PI (Resident 1). Resident 1 developed a PI to her sacrum (bottom of the spine), which progressively worsened and the facility failed to follow their policies regarding wound care and changes of condition and inform Resident 1's physician when her PI changed and worsened.This delayed treatment for Resident 1's PI by six days, and resulted in a worsened and infected PI. Within two days of Resident 1 discharging from the facility, she was admitted to the acute care hospital for an infected PI and sepsis (an infection in the bloodstream) and osteomyelitis of the sacrum (an infection in the bone). This failure had the potential to delay wound healing for any resident who had wounds and/or PI's and subject them to substandard quality of care.Refer to F726 Findings:Review of the National Pressure Injury Advisory Panel's (a nationally recognized resource for professionals), website document titled, NPIAP Pressure Injury and Stages, at https://npiap.com, dated September 2016 indicated;Stage 1 pressure injury: non-blanchable (skin redness or discoloration that does not fade or turn white when pressure is applied) erythema (reddening of the skin), which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes.Stage 2 pressure injury: partial-thickness skin loss with exposed dermis (the middle layer of the skin). The wound bed is visible, pink, or red, moist and may also present as an intact or ruptured serum-filled blister (a raised pocket of skin filled with fluid, caused by skin injury from friction (rubbing), heat, or certain diseases). Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue may be visible (a type of new, temporary tissue that forms during the wound healing process). These injuries commonly result from adverse microclimate (temperature and moisture on the skin), and shear in the skin (injury that occurs when skin layers are pulled in opposite directions, damaging tissues, and blood vessels beneath the skin).Unstageable Pressure Injury: Obscured (hidden or difficult to see) full-thickness skin and tissue loss. 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 (thick stringy yellow or gray dead tissue or eschar (black, brown or tan scab-like dead tissue attached firmly to the wound). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stage 3 pressure injury: full-thickness loss of skin, in which adipose is visible in the injury and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. Undermining (the destruction of tissue or injury extending under the skin edges so that the pressure injury is larger at its base than at the skin surface), and tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) may occur. Fascia (a thin fibrous connective tissue that surrounds and supports all muscles, organs, and other structures in the body), muscle, tendon (a tough, fibrous cord-like tissue that connects muscles to bone), ligament (a tough, fibrous band of connective tissue that connects two bones together, providing stability and support to joints), cartilage (a smooth, elastic connective tissue that provides support and protection to joints, bones, and other tissues in the body), are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.Stage 4 pressure injury: full-thickness loss of skin and tissue with exposed fascia, muscle, tendon, ligament, cartilage, or bone in the injury. Slough or eschar may be visible. Epibole, undermining (tissue separation that creates a pocket of dead space), and/or tunneling often occur.According to the NIH National Library of Medicine (a nationally recognized professional resource for healthcare providers), website at www.ncbi.nlm.nih.gov, dated 1/3/2024, the most common problem with Stage 3 and Stage 4 pressure injuries is infection. Bacteria in the pressure ulcer wound spreads to deeper tissues and bone causing sepsis (infection in the bloodstream) and osteomyelitis (infection in the bone). Older patients with pressure injuries have a 3.6-fold increased mortality (death) rate. Managing pressure injuries should always be done with an interprofessional approach such as consulting with a general surgeon, a wound care physician (a physician who specializes in wound care), or a dermatologist (a physician who is an expert on skin care).Review of a facility policy titled, Change in a Resident's Condition or Status revised February 2021, indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a: d. significant change in the resident's physical/emotional/mental condition.Review of the admission record for Resident 1, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included a fractured (broken) sacrum bone (the

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure nursing staff demonstrated competency in following the facility's policies in regard to wound care management and changes in resident conditions for one of two sampled residents (Resident 1) when;1.Registered Nurse (RN) A and Wound Care Nurse/ RN (WCN/RN), had not notified Resident 1's physician that Resident 1's sacrum (base of the spine) pressure injury (PI-a bedsore), had worsened. 2.WCN/RN performed conservative sharp wound debridement (CSWD, an invasive procedure to remove dead tissue from a PI using sharp instruments such as a scalpel (knife), scissors, and forceps (tweezers)), to Resident 1's PI, without a physician's order. These cumulative failures caused in a delay in the treatment and healing of Resident 1's PI and caused the PI to worsen. Subsequently, Resident 1 was hospitalized within two days after she left the facility, for sepsis (an infection in the blood stream) and osteomyelitis of the sacrum (an infection in the sacrum bone). This had the potential to negatively affect all residents who required care to heal wounds.Refer to F686 Findings:Review of a facility policy titled, Change in a Resident's Condition or Status revised February 2021 indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a d. significant change in the resident's physical/emotional/mental condition. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted.Review of the National Pressure Injury Advisory Panel's (a nationally recognized professional resource for the staging and treatment of pressure injuries a global driver of quality improvement and patient safety in healthcare) website document titled, NPIAP Pressure Injury and Stages, at https://npiap.com, dated September 2016 indicated;-Stage 1 pressure injury: non-blanchable (skin redness or discoloration that does not fade or turn white when pressure is applied) erythema (reddening of the skin), which may appear differently in darkly pigmented skin. 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Epibole, undermining (the destruction of tissue or injury extending under the skin edges so that the pressure injury is larger at its base than at the skin surface) and/or tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) often occur.According to California State regulations Title 22, S72317. Nursing Service-Administration of Medications and Treatments; (a) Medications and treatments shall be administered as follows: (l) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such orderReview of the admission record for Resident 1 indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including sacrum fracture (broken bone at the base of the spine).Review of Resident 1's admission MDS (Minimum Data Set- a federally mandated assessment tool that measures the health status in nursing home residents), dated 7/11/25, completed by Minimum Data Set/Registered Nurse (MDS/RN), section C, indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 out of 15 indicating she was cognitively intact. Section M indicated that Resident 1 had no PI's upon admission to the facility.Review of Resident 1's acute care hospital record dated 8/13/25, indicated that Resident 1 was admitted to the hospital on [DATE], two days after leaving the skilled