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	01/15/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45645 Based on observation, interview, and facility policy review, the facility failed to lock the computer screen on 1 of 2 medication carts to ensure residents' protected health information (PHI) was not visible for all to see. Findings included: An undated facility policy titled Security of Medication Cart indicated, The cart must be locked with the computer charting system secured prior to entering the resident's room.4. Medication carts must be securely locked at all times when out of the nurse's view. During an observation on 01/14/2025 at 7:50 AM, the surveyor noted the computer on the medication cart was left unlocked and Resident #28's list of medications and other PHI for other residents was visible. The nurse assigned to the medication cat was not present. At 8:05 AM, the surveyor was told the nurse assigned to the medication cart was in the dining room. The surveyor observed Licensed Vocational Nurse (LVN) #1 in the dining room. LVN #1 stated she could not leave the dining room for another 30 to 35 minutes. LVN #1 acknowledged she could not visualize the medication cart from the dining room. LVN #1 stated she would have another staff member go and lock the screen on the computer on the medication cart. LVN #1 commented that she was glad you told me otherwise it would have stayed unlocked for another 35 minutes. During an interview on 01/14/2025 at 12:19 PM, LVN #2 stated nurses must lock the medication screen to keep PHI private and ensure others do not have access to residents' PHI. During an interview on 01/15/2025 at 9:40 AM, Director of Staff Development (DSD #5 stated staff received education that the computer screen on the medication cart should be locked when the medication cart is out of the nurses' visual field. During an interview on 01/15/2025 at 10:47 AM, the Director of Nursing (DON) stated computer screens must be locked. The DON stated the expectation was for the nursing staff to protect the residents' PHI. During an interview on 01/15/2025 at 10:58 AM, the Administrator stated the expectation was for the staff to follow PHI safety policies and ensure computer monitors were locked to protect residents' PHI.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39438 Based on observation, interview, record review, and facility policy review, the facility failed to implement a water management program as directed by their policy. This deficient practice had the potential to affect all residents who currently resided in the facility. The facility further failed to ensure a nurse washed her hands prior to medication administration, did not handle medication with her bare hands, and did not administer medications to a resident that had fallen on top of the medication cart for 1 (Resident #15) of 3 residents observed for medication administration. Findings included: 1. The facility policy titled, Legionella Water Management Program, revised 09/2022, revealed, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation I. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team consists of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. The director of environmental services. 3. The purposed of the water the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The policy specified, 5. The water management program includes the following elements: a. An interdisciplinary water management team (see above); b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. During an interview on 01/15/2025 at 11:20 AM, the Maintenance Director stated he had been employed at the facility for one year. He confirmed he had not tested the water for Legionella and had not implemented the facility policy. During an interview on 01/15/2025 at 11:42 AM, the Director of Nursing (DON) stated she believed the maintenance staff was generally responsible for the water management program. The DON stated she could not find the result of the last time water testing was done. During an interview on 01/15/2025 at 11:50 AM, the Administrator stated the facility had been monitoring the water, but changed maintenance staff, and Legionella was not a part of their orientation. Per the Administrator, the water should be tested annually, and he was not sure when the last time the water was tested . 45645 2. A facility policy titled, Handwashing/Hand hygiene, revised 10/2023, indicated, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to the other personnel, residents, and visitors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled, Med [Medication] Pass Infection Control Review, dated 06/01/2023, indicated, Do not touch meds [medications] with ungloved hands. The policy specified, Use hand hygiene prior to handling medication and after administering to resident. Place a barrier between the cart and the medication while preparing the medication. A Resident Face Sheet, indicated the facility admitted Resident #15 on 09/10/2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of hypertension, paroxysmal atrial fibrillation, angina pectoris, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2024, indicated Resident #15 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. During medication administration observation on 01/14/2025 at 9:07 AM, Licensed Vocational Nurse (LVN) #1 did not wash or sanitize her hands before she prepared medications for administration for Resident #15. LVN #1 also handled the resident's medications with her bare hands. It was also noted, two pulls fell on top of the medication cart and placed them in the medication cup to be administered to the resident. During an interview on 01/14/2025 at 9:48 AM, LVN #1 stated she should not have handled the resident's medications with her bare hands. LVN #1 stated she should have discarded the medications that fell on to to the top of the medication cart. During an interview on 01/14/2025 at 12:19 PM, LVN #2 stated nurses must sanitize or wash their hands prior to administration of medication, and nurses must pour the resident's medication directly into the medication cup. Per LVN #2, if a pill hit the floor or an uncleaned surface, the medication must be tossed out. During an interview on 01/15/2025 at 9:31 AM, the Infection Preventionist stated nurses must wash hands, put medication in a cup, and not touch the medication with their bare hands. During an interview on 01/15/2025 at 10:47 AM, the Director of Nursing (DON) stated the residents' medication should not be touched with a nurse's bare hands, and when dropped those pills should be discarded. The DON said the expectation was for nurses to follow the protocols adopted by the facility such as washing hands before and after administration of medications. During an interview on 01/15/2025 at 10:58 AM, the Administrator stated staff must comply with infection control protocols such as wash or sanitize their hands and not touch medications with their bare hands.