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	04/24/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to ensure food safety and sanitation guidelines were followed when:There was an undated gallon of milk in the refrigerator that was partially used, undated bags of bread in the dry goods storage area, an undated box of individual jelly packets in the dry goods storage area.There was a box of potatoes stored on the floor of the dry goods storage area, and a box of paper dining napkins stored on the floor of an outdoor storage area.There was brown crusty debris on baking pans, and the red and green cutting boards had cuts in the surfaces.The ice machine had a pale brown substance in the internal ice chute (where the ice comes down from the storage bin).These failures had the potential to cause foodborne illnesses for all residents of the facility who ate food prepared by the kitchen and used ice.Findings:During a tour of the kitchen on 4/21/26 at 9:58 am, the Dietary Aid (DA) confirmed there was a gallon of milk in the refrigerator which was not dated upon opening and that it should have been dated.During a tour of the kitchen on 4/21/26 at 10:07 am the Certified Dietary Manager (CDM) confirmed:There was an undated bag of bread in the dry goods storage area, and an undated box of individual jelly packets in the dry goods storage area, and they should have been dated.There was a box of potatoes stored on the floor of the dry goods storage area, and a box of paper dining napkins stored on the floor of an outdoor storage area, and they should not have been stored on the floor.There was brown crusty debris on baking pans, and the red and green cutting boards had cuts in the surfaces, and that the pans should not have crusty brown debris on them and the cutting boards should not have cuts in the surfaces.During a concurrent observation, interview, and record review on 4/24/26 at 10:08 am, the Maintenance Director (Maint) confirmed there was a pale brown substance observed on a clean white paper towel used to wipe the inside of the ice machine's ice chute. Maint confirmed that the inside of the ice storage bin was not clean. Maint indicated that he had just started the job and did not know how to clean the ice machine, and review of the facility's records titled, Preventative Maintenance Log Quarterly Ice Machine Service indicated that the ice machine had last been cleaned on 11/21/25, and that the previous cleanings were done on 8/23/25, 5/22/25, and 2/20/25.A review of the USDA Food Code 2022, section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) .Ready-to-eat, time/temperature control for safety food .shall be clearly marked to indicate the date. (D) (3) Marking the date or day the original container is opened in a food establishment.A review of the USDA Food Code 2022, section 3-305.11 Food Storage. (A) .Food shall be protected from contamination by storing the food: (1) In a clean, dry location, (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.A review of the USDA Food Code 2022, section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.A review of the USDA Food Code 2022, section 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-Contact Surfaces shall be: smooth.A review of the USDA Food Code 2022, section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) .single-service and single-use articles shall be stored: (3) At least 15 cm (6 inches) above the floor.A review of a facility policy titled, Kitchen Sanitation (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reviewed 1/16/26 indicated, The facility is committed to maintaining a clean, sanitary, and safe kitchen environment in compliance with all applicable federal, state, and local regulations, including California Department of Public Health (CDPH) guidelines and Title 22 requirements. Proper sanitation practices are essential to prevent foodborne illness and ensure the health and safety of residents, staff, and visitors. And 8. Cleaning Schedules A written cleaning schedule must be maintained, specifying: Daily, weekly, and monthly tasks, responsible staff, verification/sign-off logs. Supervisors must monitor compliance and document completion.Review of a facility policy titled, Food Receiving and Storage dated 11/1/22 indicated food in dry storage areas are kept at least 6 inches off the floor.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure that one of twelve residents sampled (Resident 8) right to have an Interdisciplinary Team Meeting (IDT meeting, a meeting where the Interdisciplinary Team, a group of facility managers, discuss the care and services that the facility provides to their residents) with all the team members present to ensure decisions made regarding Resident 8 was in their best interest.This failure had the potential to result in decisions being made about Resident 8's health care that were not in their best interest.Refer to F841Findings:Review of a facility policy titled Consent: Residents Unable to Provide Informed Consent and Without a Health Care Decision-Maker- CA reviewed 1/16/26 indicated, It is the policy of this facility that an Interdisciplinary Team can make treatment decisions for residents when a physician determines that resident is unable to provide informed consent for a proposed treatment intervention because they cannot articulate a decision or cannot understand the risks or benefits of a proposed intervention and where the resident had no health care decision-maker to consent to the proposed intervention. And 2. Interdisciplinary team: A team comprised of at least the following individuals.Attending Physician.Review of Resident 8's admission Record, dated 9/29/25, indicated that they were admitted to the facility on [DATE] with diagnoses which included mild cognitive impairment (impairment involving noticeable memory or thinking problems including poor judgment).Review of Resident 8's quarterly Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) BIMS (Brief Interview for Mental Status-a cognitive assessment tool used to screen for memory, orientation, and judgement status ability) dated 2/19/26, completed by the Social Services Director (SSD) indicated that Resident 8 had a score of 6 out of 15 indicating poor decision-making ability.Review of Resident 8's health record titled Special Instructions, undated, indicated, Resident does not have capacity to make decisions; Surrogate (a substitute who acts on another person's behalf) decision-maker is the MD (Medical Director).During an interview on 4/23/26 at 4:42 pm the facility Medical Director (MD) indicated that she was not required to be at the IDT meetings and that the Director of Nursing (DON) gathers information at the IDT meetings and they review it later.During an interview on 4/24/26 at 8:15 am with the DON and the facility Administrator (Admin), the DON indicated that there had been no IDT meetings to make decisions for Resident 8 but rather that the MD had been making decisions for Resident 8.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record reviews, the facility did not ensure one out of 12 sampled residents (Resident 46) was able to safely self-administer medication when Resident 46's Albuterol inhaler (a fast-acting medication that opened the airways in the lungs and made breathing easier) was stored at the bedside and available for use. This had the potential for overdosing or incorrect usage which could lead to a decline in health status. Findings: A review of the facility's policy and procedure (P&P) titled, Medication, Storage at Bedside, dated 1/16/26, indicated, that medications could only be kept at a resident's bedside if there was a Physician's order and the Interdisciplinary Team (IDT, a group of medical professionals who met to discuss residents' care) had evaluated and approved the safety of self-administration A review of Resident 46's admission Record, dated 4/14/26, indicated admission to the facility on 4/14/26 with the diagnoses of atrial fibrillation (top part of the heart shakes instead of beating effectively causing an irregular heartbeat) and hypertension (high blood pressure). During a concurrent observation, interview, and record review, on 4/23/26 at 9:09 am, located in Resident 46's room, with Licensed Nurse (LN) A, an Albuterol inhaler was observed on the bedside table. LN A confirmed the observation and reviewed Resident 46's Physician's order dated 4/16/26. LN A confirmed, the Physician's order indicated that Resident 46 could keep the Albuterol inhaler at the bedside. During an interview on 4/23/26 at 11:59 am, Director of Nursing confirmed, there was no IDT note present in Resident 46's electronic medical record indicating that the IDT had assessed or approved Resident 46's ability to safely self-administer the Albuterol inhaler.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on interviews and record reviews, the facility did not ensure there was ongoing communication regarding resident rights during group activities. This had the potential for residents not to know how to effectively exercise their rights.Findings: A review of the Resident [NAME] of Rights, dated 8/1/25, indicated that residents had the right to be fully informed of their rights at the time of admission and during their stay in the facility. A review of the Resident Council Minutes, dated 10/23/25 through 4/16/26, did not include any information about resident rights being discussed. During an interview on 4/23/26 at 10:01 am, five out five confidentially interviewed residents were asked if the facility talked about or reviewed resident rights with them. Five out of five confidential residents indicated resident rights were not discussed during Resident Council meetings (a group of residents that meet monthly to discuss care concerns and their rights). Activities Director (AD) was present during the Resident Council at the request of the residents and confirmed, resident rights had not previously been discussed. AD stated, I haven't ever done that.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the most recent recertification survey (an evaluation of the facility to ensure they are compliant with federal regulations, and clinical quality) was available to the residents of the facility.This failure resulted in a violation of resident rights. Findings:During a confidential interview of facility Resident Council (a group of residents who regularly meet to advocate for their right) on 4/23/26 at 10:01 am, the attendees of the meeting indicated that they did not know where in the facility to find the results of surveys conducted at the facility.During a concurrent observation and interview on 4/23/26 at 10:37 am the Director of Nursing (DON) confirmed that the survey results binder was in the foyer (an entrance hall or entryway that acts as a transitional space between the outdoors and the main areas of a building, in which there is an outdoor entrance, followed by a room, and then another set of doors leading into the main area of the building) where any resident who could not open the interior doors to the foyer would be unable to access the survey results stored in an unlabeled binder on a shelf in the foyer without asking for help.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two out of twelve sampled residents (Resident 6 and Resident 25) received the necessary services to maintain good personal grooming and hygiene when:1. Resident 6 did not receive a shower for twelve days.2. Resident 25 had a dark unknown substance crusted under their fingernails.These failures resulted in frustration and discomfort for Resident 6 and placed Resident 25 at risk for negative health outcomes related to poor hand hygiene.Findings: 1.Review of a facility policy titled ADLs (Activities of Daily Living e.g., feeding, bathing, dressing), Services to carry out reviewed 2/1/26 indicated, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities.2. Residents who are unable to carry out activities of daily living will receive necessary services to maintain.Personal hygiene. Review of Resident 6's admission record indicated admission to the facility on 2/25/26 with diagnoses which included rhabdomyolysis (a condition in which muscles breakdown and could cause organ damage, pain, or weakness) and generalized muscle weakness. Review of Resident 6's Minimum Data Set (MDS is a resident assessment tool) Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 3/2/26 and completed by the Social Services Director (SSD) indicated a score of 15 out of 15 which indicated good decision-making ability. During an interview on 4/21/26 at 11:20 am, Resident 6 indicated that they had not received a shower from 4/3/26 until 4/15/26. Resident 6 indicated that she usually got showers on Tuesdays and Fridays. Resident 6 indicated that not receiving a regular shower made her frustrated and uncomfortable. During a review of Resident 6's record titled MDS 3.0 Section GG – Functional Abilities (how much help a resident needs to do different ADL tasks) dated 3/3/26 and completed by the MDS nurse indicated that Resident 6 needed partial assistance from staff for bathing. During a concurrent interview and record review on 4/22/26 at 3:33 pm, with the Director of Staff Development (DSD), of a facility record titled Shower Schedule no date, the DSD confirmed that Resident 6 was scheduled to receive showers on Tuesdays and Fridays. DSD confirmed that Resident 6's record titled Shower Tracking Calendar for the month of April 2026, showed that Resident 6 did not receive the showers that she should have received on Tuesday 4/7/26 and Friday 4/10/26. 2. The facility policy titled Nail Care; Routine Procedure, dated 1/16/2026, indicated It is the policy of this facility to promote cleanliness, safety, and neat appearance. The facility policy titled Hand Hygiene dated 1/16/2026 indicated This facility considers hand hygiene the primary means to prevent the spread of infections. Residents. will be encouraged to practice hand hygiene. Resident 25 was admitted on [DATE] with diagnoses that included dementia, Parkinsonism (movement problems,) cognitive communication deficit (difficulty speaking) and need for assistance (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with personal care. The record for Resident 25 was reviewed. Their most recent Quarterly Minimum Data Set (MDS - a resident assessment tool,) dated 1/29/26, indicated Resident 25 was dependent upon staff for toileting hygiene, bathing, and personal hygiene. During an observation on 4/21/26 at 10:30 am, Resident 25's fingernails had a dark dry substance caked under their fingernails on both hands. The nails on both hands appeared to be dirty and untrimmed. During a concurrent observation and interview, on 4/22/26 at 10:25 am, Licensed Nurse (LN) D was asked about Resident 25's fingernails. LN D confirmed that the resident's nails were dirty and needed to be trimmed. LN D confirmed that Resident 25 was dependent upon staff for nail care and hand hygiene. LN D indicated that, for dependent residents, nail care was carried out as needed or twice weekly at the time a resident showers. LN D reviewed the shower schedule and confirmed that Resident 25 had received a shower earlier in the day and was not able to find documentation [NAME] indicated that nail care was offered. LN D confirmed that this placed Resident 25 at increased risk for infections or to spread germs to others.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure that two of two Certified Nurse Aid (CNA) staff currently providing resident care received a performance evaluation annually. This resulted in the facility failing to asses staff's knowledge and skills to ensure staff had adequate skills and knowledge to provide quality care to all residents. During a concurrent interview and record review, on 4/24/26 at 9:00 am, with the Director of Nursing (DON) and the Director of Staff Development (DSD), both confirmed that a process to ensure all CNAs received annual evaluations had not been implemented by the facility. DSD indicated she was aware that staff performance evaluations had not been carried out annually, but was unclear how long this had been an ongoing problem. DSD confirmed that the annual evaluations were necessary to identify areas where training was needed. Both DON and DSD confirmed that these evaluations had not yet been initiated for CNA's B and C. During an interview and concurrent record review, on 4/24/26 at 11:00 am, CNA B and CNA C's employee files were reviewed with DSD and Licensed Nurse Consultant (LNCon) both confirmed the following; The employee file for CNA B was reviewed. The employee file indicated CNA B was hired 6/27/11. DSD confirmed that the most recent annual evaluation for CNA B was dated 7/2/2014 (11 years past due).The employee file for CNA C was reviewed. The employee filed indicated CNA C was hired 11/28/22. DSD confirmed that the most recent annual evaluation for CNA C was dated 8/29/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews, the facility failed to ensure their medication error rate was less than 5 percent (5%), when the Medication Administration Pass Observation reflected three medication errors out of 25 opportunities resulting in a medication error rate of 12 percent (12%) as evidenced by: Resident 8 was not provided with a Physician ordered medication,2a. Resident 46 was not provided with a Physician ordered medication; and2b. Resident 46 was administered a higher dose of a medication than what the Physician ordered. This had the potential for residents to not attain or maintain their highest practicable level of physical, mental, functional and psycho-social well-being and have adverse medication outcomes.Findings: 1. A review of the facility's policy and procedure titled, Medication Administration, dated 1/16/26, indicated, medication would be administered as prescribed by the Physician. A review of Resident 8's admission Record, dated 9/29/25, indicated, admission to the facility on 9/29/25 with the diagnosis of bipolar disorder (a mental health condition that included extreme and intense mood swings). A review of Resident 8's Physician's order, dated 1/31/26, indicated that the physician prescribed Depakote (an anticonvulsant medication that was being used to treat bipolar disorder) 125 milligrams (a unit of measure) to be taken by mouth once a day. During a concurrent observation and interview on 4/23/26 at 8:39 am, Licensed Nurse (LN) A was observed preparing Resident 8's morning medications and did not administer the Depakote. LN A indicated Resident 8 was out of Depakote and it was on order with the pharmacy. 2a. A review of Resident 46's admission Record, dated 4/14/26, indicated admission to the facility on 4/14/26 with the diagnoses of atrial fibrillation (top part of the heart shakes instead of beating effectively causing an irregular heartbeat) and hypertension (a high blood pressure). A review of Resident 46's Medication Administration Record (MAR), dated 4/23/26, indicated that on 4/17/26, the Physician ordered two Lidocaine patches 4 percent (%) (pain relief patch applied to the skin) to be applied to painful areas once a day. During a concurrent observation and interview on 4/23/26 at 9:09 am, LN A was observed preparing Resident 46's morning medication and did not provide the Lidocaine patches. LN A confirmed that the facility was out of Resident 46's Lidocaine patches and stated, I'll have to call the pharmacy to get them. 2b. A review of Resident 46's MAR, dated 4/23/26, indicated that the Physician prescribed Fluticasone nasal spray (liquid allergy medication administered in the nose) 50 micrograms per each spray. The directions indicated one spray in each nostril, once a day. During a concurrent observation and interview on 4/23/26 at 9:09 am, LN A handed Resident 46 the Fluticasone without providing any verbal instructions. Resident 46 administered two sprays to the left nostril and three sprays to the right nostril. LN A confirmed the observation and indicated the Physician's order indicated one spray per nostril. During an interview on 4/23/26 at 11:59 am, the Director of Nursing (DON) was asked who was responsible to ensure that residents did not run out of medication. DON stated, all nurses are responsible to ensure meds do not run out but, ultimately I am responsible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews, the facility did not ensure that medications stored in one of two medication carts contained labels for use that matched the Physician's orders for Resident 8. This failure had the potential to cause a medication error or for medication to run out early. Findings: A review of the facility's policy and procedure (P&P) titled, Labeling and Storage of Drugs, dated 1/16/26, indicated, medication labels would include specific directions for use. The P&P indicated, when the medication label was incorrect, the medication would be returned to the pharmacy, or the Licensed Nurse (LN) would flag the medication label indicating there was a change in the directions for use. A review of Resident 8's admission Record, dated 9/29/25, indicated, admission to the facility on 9/29/25 with the diagnoses of mild cognitive impairment (a decline in memory or thinking that was not related to normal aging) and breakdown of internal fixation device (hardware such as metal plates, rods, or screws) of right humerus (upper arm bone). During a concurrent observation, interview, and record review, on 4/23/26 at 8:39 am, LN A was observed preparing Resident 8's morning medication. The label on the medication blister pack (a card that contained individually wrapped medication) indicated Celebrex (a medication used to treat pain) 100 milligrams (mg, unit of measure), take one capsule by mouth, daily (every 24-hours), as needed. LN A reviewed the Physician's orders and confirmed there were two separate Physician's orders for Celebrex. LN A confirmed one Physician's order indicated Celebrex 100 mg would be administered once every morning (scheduled) and the other Physician's order indicated Celebrex would be administered once every 24 hours as needed for pain. LN A confirmed there was no blister pack located in the medication cart for the Celebrex that was ordered to be given daily and indicated that LN A had always utilized the blister pack that was labeled for PRN (as needed) use. During an interview on 4/23/26 at 11:59 am, the Director of Nursing (DON) was asked how the facility ensured the blister pack medication label matched the Physician's order. DON stated, ideally we get a new label.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview, record review, and policy review, the facility did not ensure that the Medical Director (MD) effectively implemented resident care policies for one of two sampled residents (Resident 8) when:1. The facility failed to obtain a resident representative (RP, medical decision maker) who was unaffiliated with the facility (a person who is not connected to the business) for Resident 8.2. The MD acted as Resident 8's RP.This had the potential to result in decisions that were in the interest of the facility rather than the interest of Resident 8.Findings:Review of a facility policy titled, Consent: Residents Unable to Provide Informed Consent and Without a Health Care Decision-Maker - CA, reviewed 1/16/2026, indicated that the facility was responsible to assist residents in obtaining an RP if they were no longer able to make their own decisions, or had no family who could fill that role.Review of a facility policy titled Compliance Manual undated, indicated Personnel and employees.should not place themselves in a position where their actions, or the activities or interests of others with whom they or a member of their family may have a financial, business, professional, family, or social relationship.Examples of conflicts of interest include.A direct or indirect interest in any transaction which might in any way affect a person's objectivity, independent judgment, or conduct in carrying out his or her job responsibilities.Review of a facility document titled, Medical Director Attestation of Compliance with Health and Safety Code dated October 17, 2025 As medical director I declare and attest to awareness of, and responsibility for ensuring profession and facility compliance with all applicable.governing state and federal laws.Review of Resident 8's admission Record dated 9/29/25, indicated admission to the facility on 9/29/25 with the diagnosis of included mild cognitive impairment (impairment involving noticeable memory or thinking problems including poor judgment).Review of Resident 8's Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 2/19/26, completed by the Social Services Director (SSD) indicated that Resident 8 had a score of 6 out of 15 indicating poor decision-making ability.Review of Resident 8's health record titled Special Instructions, undated, indicated Resident does not have capacity to make decisions; Surrogate (a substitute who acts on another person's behalf) decision-maker is the MD.Review of Resident 8's medical record titled, Encounter - Nursing Home Visit Date of service: 01/05/26 written by MD indicated SSD informed me that patient refused to have sister as decision maker.I went in with patient with SSD and reminded him I had been his doctor for 15 years - since 2011. He states he remembered and when I asked him if I could be his decision maker if he is not able, he clearly and happily agreed. Asked him a second time and received the same answer.During an interview on 4/21/26 at 3:48 pm the DON indicated that Resident 8 did not want his sister to be the RP and Resident 8 did not currently have an RP. The DON indicated that the MD was acting as an intermediary between Resident 8 and his sister. The DON indicated that by the time Resident 8 arrived at the facility his condition was such that he was unable to make his own decisions, but that the MD knew Resident 8 and his sister before Resident 8's condition deteriorated and that the MD called Resident 8's sister when there were decisions to be made about Resident 8's care.During a phone interview on 4/23/26 at 4:42 pm the MD indicated that Resident 8's sister refused to be his decision maker. When asked if the MD knew the facility's policy on responsible parties, the MD stated Nope. and indicated that she did not feel like it was her responsibility to know non-medical policy. When asked how the IDT was involved in Resident 8's decision making, the MD indicated that the IDT meetings happen on Mondays and that she was not required to be at them, that the DON gathers the information from the meetings and reviews the information with her. When asked if the facility had reached out to the Department of Aging to obtain a patient representative for Resident 8, the MD stated No, because Resident 8 would not be able to (continued on next page)

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	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta Healthcare	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.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	express what he wants to someone he doesn't know, and I've known him forever and know what he wants.During a concurrent interview and record review, on 4/23/26 at 4:59 pm, the SSD stated that Resident 8's sister, would gladly be his RP, but he says no. When asked if the facility contacted the Department of Aging (and agency assists in signing consent forms for people who have no RP), the SSD indicated that she believed that the DON did.During an interview on 4/23/26 at 5:10 pm, the DON indicated that she believed that she had contacted the Department of Aging related to Resident 8 and obtaining a patient representative for him, but that she was not sure if she could access the email. No further documentation was produced related to obtaining a patient representative via the Department of Aging for Resident 8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to develop, implement, and maintain an in-service training program for two of two Certified Nursing Assistants (CNAs) to ensure areas of deficiencies in job performance that were identified during annual performance reviews were addressed and ensure that the facility provided 12 hours of continuing education for CNAs. This had the potential to negatively impact the quality of care to residents, particularly those with specialized care needs such as those with dementia or other cognitive impairments.Findings:During a concurrent interview and record review on 4/24/26 at 9:00 am, with the Director of Nursing (DON) and the Director of Staff Development (DSD,) both were asked to described the facility's current training program for Certified Nurse Assistant (CNA) staff. DSD stated she did not have documentation of in-service trainings to meet the annual requirement of 12 hours of training that included dementia management, abuse training, and training to address any areas of weakness identified during annual evaluations. DON and DSD confirmed that a process to ensure that all CNAs received annual evaluations had not been implemented by the facility. During a concurrent interview and record review on 4/24/26 at 11:00 am, employee files were reviewed with DSD and Licensed Nurse Consultant (LN Con.) Both confirmed the following: The employee file for CNA B was reviewed. The employee file indicated CNA B was hired 6/27/11. DSD confirmed that the most recent annual evaluation for CNA B was dated 7/2/14. DSD confirmed the most recent training was for hand washing and the use of personal protective equipment (gloves, gowns, mask), dated 4/16/25. DSD confirmed CNA B's employee file did not contain documentation that CNA B had received the 12 hours of required training.The employee file for CNA C was reviewed. The employee filed indicated CNA C was hired 11/28/22. DSD confirmed that the most recent annual evaluation for CNA C was dated 8/29/24. DSD confirmed that CNA C's employee file did not contain documentation that CNA C had received the 12 hours of required training.