STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555356	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUARTZ HILL POST ACUTE	**2120 BENTON DRIVE REDDING, CA 96003**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect two of two sampled residents (Residents 1 and 2) from abuse when they were left unattended and unprotected from each other in the activity room (day room) on the Memory Loss Unit (MLU). Residents 1 and 2 had severe cognitive impairment and known histories of behaviors that placed them at risk for resident to resident altercations. This failure resulted in Residents 1 and 2 engaging in a physical altercation and Resident 1 sustaining a skin tear to her left lower leg. Findings: A review of the facility's Abuse Prevention Program policy and procedure, revised December 2016, indicated, As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including . other residents . a. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 had a history of [REDACTED]. A review of a quarterly Minimum Data Set (MDS-an assessment tool), dated 9/26/19, indicated that Resident 1 had severe cognitive deficit and was unable to make her own medical decisions. A review of an Interdisciplinary Team (IDT) Progress Note, dated 12/9/19, read, Around 4 pm, today, (Resident 1) sat next to another Resident in the Activity Room(day room) to watch TV. This other female had a pillow under her arms on the table. (Resident 1) touched the pillow and this upset the other resident, who also has Alzheimer's. The two had a bit of a tug of war with the pillow until staff promptly separated them. (Resident 1) tried to kick the other Resident but she grabbed (Resident 1's) calf and caused a small skin tear to the back of her leg . A review of a Change of Condition Progress Note, dated 12/9/19 at 3:23 pm, indicated, Residents were seated in day room when one member went to take another members pillow from her and the other member fought to keep the pillow. The Assessment indicated, Minor abrasion-skin tear to right lower leg, posterior aspect noted . A review of a Weekly Skin Alteration Report, dated 12/10/19, indicated Resident 1 had a partial thickness skin tear that measured 3.5 centimeter (cm) x 1.5 cm x 0.1 cm to the left lower leg. A review of a care plan titled, Potential for Negative Emotional or Psychosocial Well-being Related To: Resident to Resident Altercation, initiated 12/9/19, indicated, (Resident 1) touched another Alzheimer Resident's pillow and she and the other Resident had a little tug of war with the pillow. The other Resident scratched the back of Resident 1's right calf when Resident 1 tried to kick her. During an observation and interview with Resident 1 on 12/12/19 at 1:45 pm, Resident 1 was sitting in a chair outside the medication room. Resident 1 did not recall the incident when she attempted to take Resident 2's pillow while in the day room and when Resident 2 scratched her leg causing a laceration. b. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2 had a history of [REDACTED]. A review of Resident 2's Weekly Progress Note, dated 12/1/19, under Mental Status, indicated Dementia with behaviors, confusion & forgetfulness, patient has behaviors of hoarding objects, has outburst & strike out on (occasion) . Under Behaviors/Mood, it indicated, monitored for anger affect and hitting staff. Hoarding objects, taking others pillows . A review of an IDT Progress Note, dated 12/9/19 at 6:28 pm, indicated that around 4 pm today Resident 2 was in the Activity Room watching TV. She had a pillow under her arms. Resident 1 sat to Resident 2's right at the table. Resident 1 began touching Resident 2's pillow. Subsequently, they had a tug of war with the pillow . Resident 1 tried to kick Resident 2 but Resident 2 grabbed Resident 1's calf, scratching her calf with her fingernails and causing a skin tear on the backside of Resident 1's leg. A review of a Care Plan titled, Resident to Resident Altercation: Potential for Negative Emotional or Psychosocial Well-Being Outcome, dated 12/9/19, indicated, (Resident 2) had a tug of war with a pillow when another Alzheimer Resident touched it. The other Resident went to kick (Resident 2) and she grabbed her leg which caused a small skin tear to the other resident. During an observation and interview with Resident 2 on 12/12/19 at 2 pm, Resident 2 was in the day room sitting in a chair at the dining table, watching television. Resident 2 had both of her arms laying across a pillow on the table in front of her. Resident 2 did not recall the incident when Resident 1 attempted to kick her and she scratched Resident 1's leg. On 12/12/19 at 4 pm, during an observation of Resident 1's right lower leg with Licensed Vocational Nurse (LVN 1), LVN 1 was cautious when attempting to look at the leg skin tear and stated she didn't want to get injured (by Resident 1 striking at her). On 12/13/19 at 11 am, during an interview with the facility Social Services Director (SSD), she stated that Resident 2 would certainly fight for something she wanted. SSD stated Resident 2 was able to verbalize and come and go independently. SSD stated Resident 2 had been known to strike out at staff and other residents, especially Resident 1. SSD stated Resident 1 and Resident 2 have had frequent interactions, usually verbal. An interview was conducted with the facility Activity Assistant (AA) on 12/13/19 at 11:27 am. AA stated she worked on the MLU and was on the unit on 12/9/19. She stated while she was sitting in front of the nurse's station with another resident, a second resident told her, They are fighting in there. AA stated when she went into the day room, she observed Residents 1 and 2 fighting over a pillow and that Resident 1 kicked up at Resident 2. She stated Resident 2 was standing and grabbed Resident 1's leg around the ankle with both hands and scratched Resident 2's leg with her long nails. AA recalled that when she left the day room before the incident, Resident 2 was sitting at the table with her pillow under her arms. AA stated that she was supposed to monitor the day room, but she was unable to at the time of the incident as she was sitting outside of the day room with another resident. AA stated there was usually someone in the day room but the licensed nurse was distracted with the doctor and she was distracted with two other residents outside the day room. On 12/13/19 at 11:41 am, during an interview with LVN 2 she stated the residents in the MLU required monitoring from the time they got out of bed. She stated someone was always supposed to be in the day room to monitor the residents and to ensure no one was injured. LVN 2 stated that residents should never be left unattended in the day room.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 1 and 2), with known histories of behaviors that placed them at risk for resident to resident altercations, received adequate supervision when they were left unattended in the day room on the Memory Loss Unit (MLU). This failure resulted in Residents 1 and 2 engaging in a physical altercation, and Resident 1 sustaining a skin tear to her left leg. Findings: A review of the facility's Behavior Policy and Procedure, revised March 2015, indicated that therapeutic and recreational activities will be supervised and supported at all times during the day. a. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 had a history of [REDACTED]. A review of a quarterly Minimum Data Set (MDS-an assessment tool), dated 9/26/19, indicated that Resident 1 had severe cognitive deficit

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and was unable to make medical decisions. A review of an Interdisciplinary Team (IDT) Progress Note, dated 12/9/19, read, Around 4 pm, today, (Resident 1) sat next to another Resident in the Activity Room to watch TV. This other female had a pillow under her arms on the table. (Resident 1) touched the pillow and this upset the other resident, who also has Alzheimer's. The two had a bit of a tug of war with the pillow . (Resident 1) tried to kick the other Resident but she grabbed (Resident 1's) calf and caused a small skin tear to the back of her leg . A review of a Change of Condition Progress Note, dated 12/9/19 at 3:23 pm, indicated, Residents were seated in day room when one member went to take another members pillow from her arms and the other member fought to keep the pillow. The Assessment indicated that Resident 1 received a Minor abrasion-skin tear to right lower leg . A review of a Weekly Skin Alteration Report, dated 12/10/19, indicated Resident 1 had a skin tear that measured 3.5 centimeter (cm) x 1.5 cm x 0.1 cm to her left lower leg (rear). A review of a care plan titled, Potential for Negative Emotional or Psychosocial Well-being Related To: Resident to Resident Altercation, initiated 12/9/19, indicated Resident 1 touched Resident 2's pillow. Resident 1 and Resident 2 had a little tug of war with the pillow. Resident 2 scratched the back of Resident 1's right calf when Resident 1 tried to kick Resident 2. During an observation and interview with Resident 1 on 12/12/19 at 1:45 pm, Resident 1 did not recall the incident when she attempted to take Resident 2's pillow while in the day room, when she attempted to kick Resident 2, or when Resident 2 scratched her leg causing a laceration. b. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2 had a history of [REDACTED]. A review of an IDT Progress Note, dated 12/9/19 at 6:28 pm, indicated that around 4 pm today, Resident 2 was in the Activity Room watching TV. She had a pillow under her arms. Another female resident with Alzheimer's sat to Resident 2's right at the table. Resident 1 began touching Resident 2's pillow. Subsequently, they had a bit of a tug of war with the pillow . The other resident tried to kick Resident 2 but Resident 2 grabbed her calf and gave her a small skin tear on the backside of her leg. A review of a Care Plan titled, Resident to Resident Altercation: Potential for Negative emotional or psychosocial well-being outcome, dated 12/9/19, indicated that Resident 2 had a tug of war with a pillow when another Alzheimer resident touched it. The other resident went to kick Resident 2 and she grabbed her leg which caused a small skin tear to the other resident. During an observation and interview with Resident 2 on 12/12/19 at 2 pm, Resident 2 was in the day room sitting in a chair at the dining table with a pillow on the table in front of her. Both of Resident 2's arms were laying on top on the pillow. Resident 2 did not recall the incident when Resident 1 attempted to kick her or when Resident 2 scratched Resident 1's leg. On 12/12/19 at 4 pm, during an observation of Resident 1's right lower leg with Licensed Vocational Nurse (LVN 1), LVN 1 was cautious when attempting to observe the lower leg skin tear and stated she didn't want to get injured (by Resident 1 striking at her). On 12/13/19 at 11 am, an interview with the facility Social Services Director (SSD) was conducted. SSD stated that Resident 2 would certainly fight for something she wanted. SSD stated Resident 2 was able to verbalize and come and go independently. SSD stated Resident 2 had been known to strike out at staff and other residents, especially Resident 1. SSD stated Resident 1 and Resident 2 have had frequent interactions. An interview was conducted with the facility Activity Assistant (AA) on 12/13/19 at 11:27 am. AA stated she worked in the MLU and was in the unit on 12/9/19. She stated while she was sitting in front of the nurse's station with another resident, a second resident told her, They are fighting in there. AA stated that when she went into the day room, she observed Resident 1 and Resident 2 fighting over a pillow and that Resident 1 kicked up at Resident 2. AA stated she observed Resident 2 standing and grabbing Resident 1's leg around the ankle with both hands. AA stated Resident 2 scratched Resident 1's leg with her long nails. AA recalled when she left the day room before the incident, Resident 2 was sitting at the table with her pillow under her arms. AA stated she was supposed to monitor the day room but she was unable to at the time as she was sitting out in front of the day room with another resident. AA stated there was usually someone in the day room at all times when residents were in there, but the licensed nurse was distracted with the doctor and she (AA) was distracted with two other residents outside the day room. On 12/13/19 at 11:41 am, during an interview with LVN 2, she stated the residents in the MLU required constant monitoring from the time they got out of bed. She stated someone was always supposed to be in the day room to monitor the residents and ensure no one was injured. LVN 2 stated residents should never be left unattended in the day room.