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 _____	**09/28/2020**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 1) was treated with dignity and respect when Certified Nursing Assistant (CNA) 1 treated her disrespectfully. This had the potential to result in a decline in her physical, emotional and psychosocial well being. Findings: On 4/17/20 at 12:38 pm, the California Department of Public Health (CDPH) received a report of suspected abuse towards Resident 1 by CNA 1. In a follow up report, dated 4/22/20, the facility indicated CNA 1 had not treated Resident 1 with dignity and respect. A review of Resident 1's record indicated she was admitted to the facility, on 4/12/20, with [DIAGNOSES REDACTED]. She was discharged on [DATE]. She was incontinent (unable to control her bowels and bladder). A review of the Interdisciplinary Team (IDT) note, dated 4/17/20 at 4:10 pm, indicated Resident 1 stated, on 4/16/20 at 8:30 am, she had turned on her call light to have her brief changed. CNA 1 entered her room and threw back the privacy curtain, reached over me to turn off the call light then threw that on the floor. Resident 1 then stated CNA 1 rolled her roughly side to side flopping my legs all over the place and it was painful due to my [MEDICAL CONDITION] (widespread muscle pain and tenderness). Resident 1 stated she did not feel abused but CNA 1's attitude had made her very angry. During an interview on 9/22/20 at 3:50 pm, Resident 1stated CNA 1 had an attitude. She explained she put on her call light and when CNA 1 answered it, told CNA 1 her brief needed to be changed. CNA 1 yanked back the curtain very hard, opened the cupboard door, got out a brief, then slammed the cupboard door. Resident 1 stated CNA 1 then grabbed her legs and she told CNA 1 she was being rough. CNA 1 said, I'm just trying to do my job. During an interview on 8/24/20 at 3:45 pm, the Director of Nurses (DON) stated she had spoken to CNA 1 and did not think CNA 1 intended to be rough but was in a hurry and wanted to clean up Resident 1 instead of slowing down. In a subsequent interview on 9/2/20 at 10:15 am, DON stated after this incident had been reported, she followed up with Resident 1 daily for almost a week and she remained consistent in what she said had happened. DON stated Resident 1 did not complain of anyone else during her stay at the facility. A review of the facility's disciplinary action form, dated 4/23/20, indicated CNA 1 did not treat Resident 1 with dignity and respect. During an interview on 9/1/20 at 11:40 am, CNA 1 stated she never did the things the resident said she did. She stated Resident 1 complained about everything. A review of the facility's policy titled, Quality of Life - Dignity, dated 8/2009, indicated, all residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self esteem and self-worth. Residents shall be groomed as they wish to be groomed, .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of possible abuse within two hours, when CNA 1 provided care in a rough manner to Resident 1. This resulted in late reporting to the California Department of Public Health (CDPH) and had the potential to result, in a delay by the facility, to conduct an investigation into the allegations. Findings: A review of the facility's Abuse Investigation and Reporting policy, dated 7/2017, indicated, An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in bodily injury . On 4/17/20 at 12:38 pm, CDPH received a report of suspected abuse, towards Resident 1 by CNA 1, which occurred on 4/16/20 at 8:30 am. A review of Resident 1's record indicated she was admitted to the facility, on 4/12/20, with [DIAGNOSES REDACTED]. She was incontinent (unable to control her bowels and bladder). A review of the Interdisciplinary Team (IDT-group of healthcare disciplines who discuss resident care needs) note, dated 4/17/20 at 4:10 pm, indicated Resident 1 stated, on 4/16/20 at 8:30 am, she had turned on her call light to have her brief changed. CNA 1 entered her room and threw back the privacy curtain, reached over me to turn off the call light then threw that on the floor. Resident 1 then stated CNA 1 rolled her roughly side to side flopping my legs all over the place and it was painful due to my [MEDICAL CONDITION] (widespread muscle pain and tenderness). Resident 1 stated she did not feel abused but CNA 1's attitude had made her very angry. According to the facility's investigative report, Resident 1 had a care conference on 4/16/20 at approximately 10:30 am to 10:45 am, with the Social Services Director, Licensed Nurse 1, and a therapist present. In a written statement, all three indicated Resident 1 stated CNA 1 was rough with her, opened the curtain fast, moved the bedside table fast, and had an attitude. During an interview on 8/24/20 at 3:45 pm, the Director of Nurses (DON) confirmed the possible abuse was reported by Resident 1, for the first time at her care conference, on 4/16/20 between 10:30 to 10:45 am, but was not reported to CDPH until 4/17/20 at 12:38 pm. DON stated she reported it as soon as she found out about it. She confirmed it should have been reported within two hours and has addressed this with her staff.

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.