STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555356	A. BUILDING _____ B. WING _____	C 10/19/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for one facility reported incident. Facility reported incident: 806661 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 22705, Health Facilities Evaluator Nurse A deficiency was issued for facility reported incident 806661 at F 550.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/2/22

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 550	Continued From page 1	F 550		

access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
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 tossed a pillow at her and told her to do it herself. This had the potential to result in a decline in her physical, emotional and psychosocial well being.

Findings:

On 10/8/22 at 3:23 pm, the California Department of Public Health received a report (via voicemail) that CNA 1 threw a pillow at Resident 1. A follow up written report was sent on 10/10/22.

F550	10/31/2022
Corrective Action:	
On 10/8/22 CNA 1 was suspended pending investigation. Resident 1 was assessed by DON on 10/10/22 for any kind of distress or physical injuries and was found to have none.	
Other Residents/Areas:	
On 10/8/22 CNA 1 was suspended pending investigation. In addition, no other residents complained about CNA 1's actions and behavior- even after management interviewed CNA 1's other residents.	
Systemic Changes:	
On 10/13/22 CNA 1 was in-serviced by the DSD on resident dignity and abuse, before allowing CNA 1 to return to work. By 10/31/22 all other CNAs were given abuse/dignity training by the DSD or designee.	
Monitoring:	
The DSD and Administrator will monitor and manage this process to ensure that no other staff treat residents in an undignified manner. This issue will be monitored by QAPI until we have zero incidents for 3 months.	

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F 550	Continued From page 2 A review of Resident 1's record indicated she was admitted on 10/5/22, with diagnoses that included a bowel obstruction with a drain (tube inserted into the abdominal area), shortness of breath, diabetes, and high blood pressure. During an interview on 10/13/22 at 9:20 am, Resident 1 said she had asked for a pillow to be placed behind her back and shoulder. CNA 2 was in her room when CNA 1 came in with a pillow and started pushing and pulling on her in bed. This hurt so she yelled and told CNA 1 to stop because she was moving too quick and CNA 1 stopped. CNA 2 told her that CNA 1 had the pillow she had requested. She said she told them, I don't want the pillow right this second. CNA 1 said, you're not talking to us very nicely and she told CNA 1 she didn't care. She said CNA 1 threw the pillow at her on her face/chest area and left the room. Resident 1 said she then picked up the pillow and threw it at CNA 1. Further review of the record included an Interdisciplinary Team (IDT-group of healthcare disciplines that meet to discuss resident care needs) note, dated 10/8/22, which indicated CNA 1 tossed a pillow at Resident 1 and walked out of room. An investigation note dated 10/10/22, from the Director of Nurses (DON) indicated CNA 1 said Resident 1 kept yelling at her so she said, you can't talk to us that way. Resident 1 became more upset and said she wanted to do the pillow herself. CNA 1 said she "tossed" the pillow on the bed and left when Resident 1 ordered her to leave the room. During an interview on 10/17/22 at 12:30 pm, CNA 1 said she was charting outside Resident 1's	F 550		

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F 550	Continued From page 3 room when CNA 2 told her the resident wanted a pillow. She said she got up right away, got a pillow and went in and pulled up the draw sheet to place the pillow behind the resident's back when the resident started yelling. She said Resident 1 was yelling so I asked her, don't you want the pillow. Resident 1 said just give it to me and I'll do it myself . She said she gently tossed the pillow toward Resident 1's lower body and told her to go ahead and do it herself. CNA 1 said she told the resident not to yell at us, and explained to Resident 1, she was there to help her and didn't mean to hurt her. During an interview on 10/13/22 at 9:48 am, the Administrator (Admin) said Resident 1 had asked for a pillow and CNA 1 turned her too fast. Resident 1 yelled at CNA 1 who then said she tossed the pillow on the bed not the resident. Resident 1 then picked up the pillow and threw it at CNA 1. CNA 2 no longer works at the facility and was unavailable for interview. A review of the facility's policy, "Resident Rights," dated 2/2021, indicated, "Employees shall treat all residents with kindness, respect and dignity."	F 550		