STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056222	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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** 43031 Based on observation, interview and record review, the facility failed to protect one of three residents sampled for abuse (Resident 1), from physical abuse received by staff, when a registry staff aggressively grabbed the resident ' s wrists while providing care. This failure had the potential to result in long term ill effects on the residents physical and mental health resulting in the resident ' s lack of trust towards staff for all care and negative emotional interactions. Findings: A review of Resident 1 ' s medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included, Hemiplegia and Hemiparesis following Cerebral infarct (weakness and paralysis on one side of the body following a disruption of blood supply and restricted oxygen to the brain resulting in an area of necrotic tissue in the brain), Vascular dementia (brain damage from impaired blood flow to the brain causing problems with reasoning judgment, and thought process), and Kidney Cancer. During a review of the facility ' s policy and procedure titled, Abuse Prevention Program, dated 12/2020, indicated Our residents have the right to be free from abuse .and corporal punishment ., and Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: .staff from other agencies . During an interview on 5/16/24 at 2:00 pm, with Resident 1, stated, Someone had grabbed my wrists a bit roughly. During an interview on 5/16/24 at 3:00 pm, with Certified Nursing Assistant (CNA) B, stated, CNA C grabbed Resident 1 ' s arms and pushed them down to his chest. When CNA C grabbed his wrists, CNA C said don ' t in a very aggressive voice. During an interview on 5/17/24 at 1:00 pm, with CNA C, stated, she was trying to avoid Resident 1 ' s attacks and grabbed his wrists. During an interview on 5/17/24 at 3:00 pm, with Admin, stated, the incident occurred, we substantiated it in our investigation.

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