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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056222 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Marquis Care at Shasta | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315</p> <p>Based on interview and record review, the facility failed to ensure staff demonstrated appropriate competencies (knowledge, skills, and abilities that were required to provide safe and effective care to residents) when providing care for three out of three sampled residents (Residents 1, 2, and 3) when:</p> <ol style="list-style-type: none"> Licensed Nurses (LN) did not perform an assessment of Resident 1 ' s surgical site. A Certified Nurse Assistant (CNA) documented Resident 2 received a shower when Resident 2 did not receive a shower. Residents 1, 2, and 3 experienced long call light wait times. The competency checklist for registry staff (third party staff, employed by a registry agency and travels to different facilities to work) consisted of a self-evaluation and did not include oversight for evaluation of competencies or skills. <p>These failures had the potential for an infection to go unnoticed and to negatively impact resident ' s physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> A review of the facility ' s policy and procedure (P&P) titled, Wound Care-Level II, revised 3/1/17, indicated, the purpose of the P&P was to .provide guidelines for the care of wounds to promote healing and documentation progress. The P&P indicated, LN would document wound assessments and progress of wound healing that included a description of the wound, including the size of the wound, drainage amount, or if there was a change in the condition of the wound. <p>A review of the undated Admissions Record, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of weakness and encounter for surgical aftercare following surgery on the nervous system (surgery performed on the back near or on the spine). Resident 1 was her own responsible party (RP, made own decisions).</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of the admission Minimum Data Set (MDS, an assessment tool), dated 10/16/24, Section C, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS, tested a resident ' s ability to recall information and memory). Resident 1 scored a 15, (the test was scored from 0-15 where 0 meant the resident was not able to remember and 15 meant the resident had intact memory).</p> <p>A review of Resident 1 ' s Nursing Admission Assessment, dated, 10/15/24, indicated, Resident 1 was admitted to the facility with a surgical incision and there were no signs or symptoms of an infection to the surgical site.</p> <p>A review of Resident 1 ' s Skilled Nursing Progress Note, dated 10/19/24, indicated, Resident 1 ' s had a surgical incision present and the incision was well approximated (the edges of the surgical incision fit together nicely) and there were no signs or symptoms of an infection.</p> <p>During a concurrent interview and record review on 10/30/24 at 2:10 pm, with LN A, Resident 1 ' s Skilled Nursing Progress Note, dated 10/20/24 was reviewed. LN A stated, the Skilled Nursing Progress Note indicated, Resident 1 did not have a surgical incision. LN A confirmed, LN A performed Resident 1 ' s assessment and completed the Skilled Nursing Progress Note documentation. LN A stated, Resident 1 did have a surgical incision, located on her back, and that LN A failed to document the surgical incision site on the Skilled Nursing Progress Note.</p> <p>During a concurrent interview and record review on 10/30/24 at 2:59 pm, with LN B, Resident 1 ' s Skilled Nursing Progress Note, dated 10/21/24 was reviewed. LN B stated, the Skilled Nursing Progress Note, indicated, Resident 1 did not have a surgical incision. LN B confirmed, LN B performed Resident 1 ' s assessment and completed the Skilled Nursing Progress Note documentation. LN B stated, Resident 1 did have a surgical incision on her back and that LN B failed to document the surgical incision site on the Skilled Nursing Progress Note.</p> <p>A review of Resident 1 ' s IDT Progress Note, dated 10/21/24, indicated, Resident 1 ' s . incision to spine found inflamed and hot to touch ., and there was purulent drainage (a thick, milky discharge that usually indicated the wound was infected). The IDT Progress Note, indicated, Resident 1 stated the surgical site itched and was painful.</p> <p>A review of Resident 1 ' s IDT Progress Note, dated 10/21/24 (written on the same date with a different time stamp), indicated, the facility ' s physician ordered an antibiotic (a medication that treated infections) for Resident 1.</p> <p>During a concurrent interview and record review on 11/1/24 at 8:55 am, with Director of Nursing (DON), Resident 1 ' s progress notes, dated 10/16/24 through 10/21/24 was reviewed. DON confirmed, the Skilled Nursing Progress Note, dated 10/20/24 and 10/21/24 indicated, Resident 1 did not have a surgical incision. DON confirmed, Resident 1 did have a surgical incision and stated, the expectancy was for LNs to describe what the incision looked like and if there were signs and symptoms of an infection. DON reviewed both of Resident 1 ' s IDT Progress Notes, dated 10/21/24 and confirmed, the facility ' s physician ordered an antibiotic due to an infection at the surgical site and stated there was no other documentation in Resident 1 ' s medical records that indicated when Resident 1 ' s surgical incision developed drainage or signs and symptoms of an infection and should have.</p> <p>2. A review of the facility ' s P&P titled, Charting and Documentation, revised 5/1/10, indicated, all services provided to residents would be documented in the resident ' s medical record.</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of the facility ' s P&P titled, Shower/Tub-Level II, revised 8/1/17, indicated, that each time a resident received a shower or bath, the date and time would be documented in the resident ' s medical record.</p> <p>A review of the undated, Admission Record, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnoses of surgical aftercare following surgery on the nervous system and depression. Resident 2 was her own RP.</p> <p>A review of the admission MDS, section C, dated 10/29/24, indicated, Resident 2 had a BIMS score of 15. Section GG of the MDS, indicated, Resident 2 was dependent upon facility staff for showers and baths.</p> <p>During an interview on 10/30/24, at 9:28 am, Resident 2 stated that her hair was dirty, and it was driving Resident 2 nuts and had not received a shower since admission to the facility, five days ago. Resident 2 stated, facility staff had also not offered a bed bath or provided Resident 2 with wash cloths so that Resident 2 could clean herself.</p> <p>During a concurrent interview and record review on 10/30/24 at 10:30 am, with Director of Staff Development (DSD), the Schedule for October 2024 (documentation for care provided by CNAs), dated 10/1/24 through 10/30/24 was reviewed. DSD stated, Resident 2 was scheduled to receive a shower on 10/29/24 and stated the documentation indicated, Resident 2 had received a shower on 10/29/24.</p> <p>During an interview on 10/30/24 at 11:45 am, CNA D confirmed, being responsible for providing Resident 2 with a shower on 10/29/24. CNA D confirmed, Resident 2 did not receive a shower or a bed bath and stated, CNA D documented that Resident 2 received a shower by mistake.</p> <p>3. A review of the facility ' s P&P titled, Answering the Call Light- Level 1, revised 8/1/17, indicated all facility staff was responsible for answering call lights as soon as possible.</p> <p>A review of the undated Admission Record, indicated, Resident 3 was admitted to the facility on [DATE] with the diagnoses of respiratory failure, weakness, and repeated falls. Resident 3 was his own RP.</p> <p>A review of the Resident Council Minutes (a group of residents that met monthly to discuss resident rights and concerns), dated 4/30/24, indicated, residents of the facility had experienced long call light wait times that lasted up to 30 minutes.</p> <p>A review of the admission MDS, section C, dated 10/29/24, indicated, Resident 3 had a BIMS score of 14. The admission MDS section GG indicated; Resident 3 could not move from a sit to stand position without moderate assistance from staff.</p> <p>During an interview on 10/25/24 at 1:27 pm, Resident 1 stated, I pressed the call light one time when . Resident 1 needed assistance to utilize the bathroom. Resident 1 stated, the call light rang for 45 minutes before staff came into the room. Resident 1 stated, I needed to use the bathroom. I ended up wetting myself and the nurse said my dressing [wound bandage located on Resident 1 ' s back] had urine on it. Resident 1 stated, due to long call light wait times, Resident 1 would have to yell out for staff to come assist her, and that it made Resident 1 feel uncomfortable living at the facility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 10/25/24 at 9:11 am, Resident 3 stated, waiting up to 45 minutes for facility staff to answer the call light. Resident 3 stated, usually, Resident 3 pressed the call light when Resident 3 needed water or to use the bathroom.</p> <p>During an interview on 10/30/24 at 9:28 am, Resident 2 stated on 10/28/24, it took facility staff one hour to answer the call light. Resident 2 stated inability to recall if Resident 2 needed assistance due to urinating on herself or if she pressed her call bell due to having pain. Resident 2 stated, being angry that facility staff did not answer the call light and utilized her phone to call the facility to request assistance.</p> <p>During a concurrent interview and record review on 10/30/24 at 10:30 am, with DSD, the electronic time log (Call History, captured how long it took staff to answer call lights), dated 10/10/24 through 10/30/24 was reviewed. DSD stated the Call History indicated long call light wait times for Resident 1 on: 10/17/24 at 12:51 pm for 34 minutes, 10/17/24 at 5:25 pm for 30 minutes, 10/20/24 at 7:42 am for 33 minutes, 10/21/24 at 2:24 pm for 39 minutes, 10/22/24 at 9:51 am for 47 minutes, and 10/23/24 at 5:30 pm for 41 minutes. DSD reviewed Resident 2 ' s Call History, dated 10/28/24, and confirmed at 8:35 am, Resident 2 experienced a one-hour call light wait time. DSD stated, it was everyone ' s responsibility to answer call lights as soon as possible and confirmed Resident 1 and 2 experienced long call light wait times.</p> <p>During a concurrent interview and record review, on 10/30/24 at 2:49 pm, with DSD, Resident 3 ' s Call History, dated 10/11/24 through 10/16/24 was reviewed. DSD confirmed, the Call History indicated Resident 3 had experienced long call light wait times, over 20 minutes, on two different occasions, and should not have. Upon further review of Resident 3 ' s Call History, the Call History indicated long call light wait times for Resident 3 on: 10/11/24 at 6:51 pm for 36 minutes, 10/12/24 at 1:02 pm for 26 minutes, 10/12/24 at 2:49 pm for 24 minutes, 10/15/24 at 2:42 pm for 32 minutes, and 10/16/24 at 1:26 pm for 25 minutes.</p> <p>4. The State Operations Manual (SOM), dated 8/8/24, defined competency as a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. The SOM indicated, Examples for evaluating competencies may include but are not limited to: . lectures, testing, and demonstration.</p> <p>During a concurrent interview and record review on 11/1/24 at 9:38 am, with the facility ' s Administrator (ADMIN), LN A ' s Med Surg/Skilled Nursing Skills Checklist, dated 7/3/23 and CNA D ' s CNA Skills Checklist, dated 4/17/24, was reviewed. Admin stated, the skills check lists for LN A and CNA D indicated that it was a self-assessment (where a person self-identified if they were competent or not in providing safe care to residents). ADMIN reviewed LN A ' s check list in its entirety and confirmed, the self-assessment of LN A ' s competencies and skills did not include whether LN A was competent or had appropriate skills regarding assessing wounds or providing wound care. At 9:54 am, the DSD joined the interview and record review. DSD confirmed, LN A and CNA D ' s check lists indicated they were self-assessments and stated, the facility did not validate registry staff ' s competencies and relied upon the staffing agency to do that.</p> | | |