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	09/12/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure one of three sampled residents, (Resident 1) was treated with respect and dignity during direct personal care when Certified Nursing Assistant (CNA) I rushed Resident 1 and held his arms to prevent hitting staff when the bed linen was changed. This failure had the potential to result in emotional stress, embarrassment, feelings of neglect, and the potential for negative clinical outcomes.Findings: During a review of the facility's policy revised 8/2017, titled, Quality of Life-Dignity, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with respect and dignity at all times. Treated with respect and dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. This facility's policy indicated staff shall treat cognitively impaired residents with dignity and sensitivity addressing the underlying motives or root causes for behavior and not challenging or contradicting the residents' beliefs or statements. During a review of Resident 1's record titled admission Record, indicated Resident 1 was admitted the facility on 7/30/25 with diagnoses that included Alzheimer's disease (a progressive brain disorder that slowly destroys a person's memory and thinking skills, eventually leading to dementia), vascular dementia with agitation (brain damage that affects communication, behaviors, slowed thinking, frustration and agitation), delusional disorder (a fixed, false belief), cerebral infarction (commonly known as stroke), diabetes (too much sugar in the blood), atrial fibrillation (irregular and fast heart beat), depression (persistent feelings of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), chronic pain (ongoing persistent pain), malignant neoplasm of the kidney (kidney cancer), dysphagia (difficulty swallowing) and metabolic encephalopathy (a brain dysfunction caused by an underlying condition). During a review of Resident 1's record titled, Minimum Data Set, (MDS, a resident assessment), dated 8/1/25, indicated Resident 1 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of 1of 15 and and is unable to make his own decisions. Section GG of the MDS indicated Resident 1 needed maximum assistance (helper does more than half the work) for incontinent care and personal hygiene. During a review of a record dated 7/10/25, titled, CNA/HHA/CHT Report Of Misconduct, indicated It is reported during resident care on 7/9/25 at 11:00 pm, the resident became agitated and combative, twisting and punching at staff. In house staff (CNA G) reported that a local registry staff (CNA I) had held Resident 1's hands down on his chest. CNA G told CNA I to stop three times before she would let go. During an interview on 9/10/25 at 1:23 pm, the administrator (Admin) stated, [Resident 1] has hurt some of our staff with combative behaviors, but we terminated CNA I for misconduct. I do think [Resident 1]'s rights and dignity was violated during the incident on 7/9/25 providing direct care. During an interview on 9/10/25 at 1:35 pm, the Director of Nursing (DON) stated, I am not making excuses for CNA I's conduct, but I do believe she was trying to protect herself from getting hurt. I agree [Resident 1] has combative behaviors but he has the right to be treated with respect and dignity in spite of any behaviors. During an interview on 9/10/25 2:25 Licensed Nurse (LN) C stated, [Resident 1] has delusions causing fear. I do know right in the middle of direct care, when you are not expecting he will just start hitting at you. I do confirm no staff should hold [Resident 1]'s hands or continue care if he is really upset or hitting, they should walk away and come back later. During an interview on 9/10/25 at 2:55 pm, CNA G stated, I did witness CNA I hold [Resident 1]'s hands down to his chest while we were changing the linen during direct personal care. I told her to leave the room, and I had another staff member help me complete the bed change. I reported CNA I immediately for her behavior. During an interview on 9/10/25 at 3:30 pm, the Admin and DON confirmed CNA I had not treated Resident 1 with respect and dignity while providing care, which was a violation of Resident 1's rights. Both Admin and DON confirmed treating any resident in a rude, disrespectful manner, or holding their hands down for any amount of time is unacceptable and will not be tolerated under any circumstances.