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	06/24/2026

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** Based on observations, interviews, and record reviews, the facility did not protect one of five sampled residents (Resident 2) from physical abuse when Certified Nursing Assistant (CNA) C was seen putting their hands on Resident 2's shoulders, firmly shaking Resident 2, and telling Resident 2 loudly to stop. This had the potential to result in physical harm, pain, and mental anguish.Findings: A review of the facility's policy and procedure titled, Abuse Prevention Program, dated 12/1/20, indicated, residents had the right to be free from abuse by anyone, including facility staff. A review of the Employee Safety Rules and Responsibilities, dated 3/1/26, indicated, facility staff were expected to always conduct themselves in a professional manner. A review of Resident 2's admission Record, dated 12/7/23, indicated admission to the facility on [DATE] with the diagnoses of delusional disorder (a mental health condition where a person had an unshakable, false belief that was not based in reality), dementia (a disease that caused a decline in language or thinking skills and memory loss), and Alzheimer's disease (a specific physical brain disease that caused dementia). Resident 2 was not her own responsible party (RP, decision maker). A review of Resident 2's Quarterly Minimum Data Set (MDS, a resident assessment tool), Section C, dated 5/17/26, indicated Resident 2's cognitive skills (thinking, learning, or performing daily tasks) for daily decision making was severely impaired and had short and long-term memory problems. Resident 2's Quarterly MDS, Section GG, dated 5/17/26, indicated, Resident 2 required substantial to maximum assistance (helper does more than half the effort) from facility staff to get dressed, put on or take off shoes, roll from side-to-side in bed, and to transfer out of the bed. The Quarterly MDS indicated Resident 2 was dependent on staff for toileting hygiene. A review of Resident 2's care plan (a personalized plan that outlined resident goals, emotional needs, and care instruction for facility staff) titled, Physical Aggression/Abusive, dated 9/8/24, indicated the facility staff would approach Resident 2 slowly, not invade Resident 2's personal space, staff would ensure to have Resident 2's attention before touching or speaking, and to talk to Resident 2 using a low pitch (quiet or soft) and with a calm voice to decrease or eliminate undesired behaviors. A review of the Multidisciplinary Care Conference -V 12, dated, 6/8/26, indicated that Resident 2 had behaviors that included screaming, threatening others, refusing care, and feeling anxious (worried or nervous) and agitated (upset or irritated). During a concurrent observation and interview on 6/24/26 at 10:32 pm, CNA B stated, I've noticed [CNA C] seems a little rough when providing care sometimes. CNA B indicated, approximately two weeks earlier (two weeks ago was 6/7/26 through 6/13/26), CNA B assisted CNA C while providing care to Resident 2 and during that time, Resident 2 had an increase in verbal and physical behaviors and that CNA C appeared to be overwhelmed (feeling of being unable to cope because of the demands of a situation). CNA B stated, [CNA C] grabbed [Resident 2] by the shoulders and shook [Resident 2]. CNA B indicated that CNA C had told Resident 2 to stop with a loud voice. CNA B demonstrated the described incident by placing one hand on top of both of the surveyor's shoulders and supplied pressure by squeezing, gave a firm shake, and loudly stated stop! CNA B stated, I took over [Resident 2's] care and had [CNA C] leave. CNA B indicated Resident 2 was very forgetful and CNA B remained calm, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided redirection, and was able to calm Resident 2 down. During an interview on 6/24/26 at 12:21 pm, with Administrator (Admin), CNA B's witnessed physical abuse was described. Admin indicated that would be considered an allegation of abuse.

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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 observations, interviews, and record reviews, the facility failed to report two allegations of physical abuse to the California Department of Public Health (CDPH, protected the public's health), the local police department, or the Ombudsman's office (an agency that protected resident rights) for two out of five sampled residents (Residents 1 and 2) when: 1.Resident 1 told the Resident Care Manager (RCM) that they sustained a fracture (broken bone) in the left ulna (lower arm) that resulted from rough care that was provided by two Certified Nursing Assistants (CNA). 2. CNA B indicated they had witnessed CNA C physically abuse Resident 2. These failures had the potential for abuse allegations to go unrecognized and placed residents at risk for abuse. Findings: 1. A review of the facility's policy and procedure (P&P) titled, Reporting Abuse to Facility Management, revised 10/1/22, indicated, allegations or suspicions of abuse were to be reported immediately to the facility's Administrator (Admin). The P&P indicated, allegations or suspicions of abuse would be reported immediately or within two hours to CDPH, the police department, and the Local Ombudsman's office. A review of Resident 1's admission Record, dated 7/13/12, indicated admission to the facility on 7/13/12 and had diagnoses of ageˆrelated osteoporosis (a condition that caused weak bones and increased the risk of fractures even from minor bumps or falls) and flaccid hemiplegia (inability to move half of the body) that affected the left side. On 6/16/26, Resident 1 was diagnosed with an unspecified fracture of the lower end of the left ulna (located in the wrist area), and the fracture did not require surgery. Resident 1 was their own responsible party (RP, made their own decisions). During a concurrent observation and interview on 6/23/26 at 2:00 pm, Resident 2 was observed sitting in a recliner, appeared to be in a pleasant mood and was smiling. Resident 1 indicated, on the evening of 6/6/26, two Certified Nursing Assistants (CNA) had provided Resident 1 with care and did not know their names. Resident 1 indicated the CNAs turned Resident 1 from side-to-side while in bed and when Resident 1 was being turned towards the left side of the bed, their left arm hit the bed cane (a metal grab bar that was attached to the bed), and she had stated, Ow, Ow, Ow. Resident 1 indicated that on 6/6/26, they were having difficulty with breathing, had been transported to the hospital late in the evening, and was ultimately admitted to the hospital. Resident 1 indicated, on 6/8/26, their breathing was better and turned her focus back to her left arm pain. Resident 1 reported to the hospital's Physician what had occurred when the CNAs had provided care on 6/6/26. Resident 1 indicated, the hospital's Physician ordered an x-ray (a picture of the bones) and stated, My left ulna is fractured. Resident 1 was observed to appear sad, was no longer smiling, and began to frown while shaking head from side to side while talking. Resident 1 indicated returning to the facility on 6/16/26 and had notified the Resident Care Manager (RCM) about the incident on 6/6/26. During an interview on 6/23/26 at 2:33 pm, RCM confirmed when a resident alleged that facility staff provided rough care or sustained injuries during care, it would be viewed as an allegation of abuse, Admin would be notified immediately, and Admin would provide further instructions. RCM confirmed, on 6/16/26, when Resident 1 had returned to the facility, Resident 1 alleged sustaining a fracture to the left ulna while two CNAs had provided Resident 1 with care and that it occurred prior to Resident 1 going to the hospital. RCM indicated that due to Resident 1 not reporting the allegation on 6/6/26, and had waited until 6/16/26, and there was no documentation that supported Resident 1 had any pain prior to her hospitalization, RCM did not consider this an allegation of abuse or suspected abuse. RCM confirmed, not reporting Resident 1's allegation to the facility's Admin until the morning of 6/17/26. A review of Resident 1's Progress Note, dated 6/17/26 and written by RCM, indicated that on 6/16/26, Resident 1 had returned to the facility from a hospital stay and while in the hospital, Resident 1 notified the hospital's Physician that Resident 1 had pain in the left arm due to an injury sustained at the facility while receiving care from two CNAs. The Progress Note indicated, RCM spoke with [Resident 1] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about her [left] wrist fracture and asked her when and how she thought she hurt it. She said she was being provided care in bed by two CNAs and when rolled, her [left] hand hit her bed cane and started hurting after that. 2. A review of Resident 2's admission Record, dated 12/7/23, indicated admission to the facility on [DATE] with the diagnoses of delusional disorder (a mental health condition where a person had an unshakable, false belief that as not based in reality), dementia (a disease that caused a decline in language or thinking skills and memory loss), and Alzheimer's disease (a specific physical brain disease that caused dementia). Resident 2 was not her own RP. During a concurrent observation and interview on 6/24/26 at 10:32 pm, CNA B stated, I've noticed CNA C seems a little rough when providing care sometimes. CNA B indicated, approximately two weeks earlier (two weeks ago was 6/7/26 through 6/13/26), CNA B assisted CNA C while providing care to Resident 2 and during that time, Resident 2 had an increase in verbal and physical behaviors and that CNA C appeared to be overwhelmed (feeling of being unable to cope because of the demands of a situation). CNA B stated, [CNA C] grabbed [Resident 2] by the shoulders and shook [Resident 2]. CNA B indicated that CNA C had told Resident 2 to stop with a loud voice. CNA B demonstrated the described incident by placing her hands on both of the surveyor's shoulders and applied pressure by squeezing the shoulders, gave a firm shake, and loudly stated stop! CNA B's face was a few inches away from the surveyor's face. CNA B stated, I took over [Resident 2's] care and had [CNA C] leave. During an interview on 6/24/26 at 12:21 pm, Admin confirmed the RCM did not notify Admin of Resident 1's statements regarding an allegation of abuse. The Admin, Director of Nursing, and Director of Staff Development confirmed, CNA B did not notify them regarding the abuse toward Resident 2 by CNA C that she had witnessed. Admin confirmed allegations of abuse were to be reported immediately or within two hours and the allegation of abuse for Resident 1 and witnessed physical abuse to Resident 2 had not been reported to CDPH, the local police department, or to the Ombudsman's office.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not thoroughly investigate an allegation of abuse for one of two sampled residents (Resident 1) when Resident 1 reported that facility staff provided rough care that caused an injury. This failure placed residents that lived in the facility at risk for further potential abuse. Findings: A review of the facility's policy and procedure (P&P) titled, Abuse Investigations, revised 10/15/20, indicated that when an allegation of abuse was reported, the facility was required to thoroughly investigate it. The P&P indicated that the investigation included interviewing any possible witnesses, such as staff, the resident's roommate, and other residents cared for by the accused staff member. A review of Resident 1's admission Record, dated 7/13/12, indicated admission to the facility on 7/13/12 and had been diagnosed on [DATE] with ageˆrelated osteoporosis (a condition that caused weak bones and increased the risk of broken bones from minor bumps or falls). On 7/10/19, Resident 1 was diagnosed with flaccid hemiplegia (inability to move half of the body) that affected the left side. On 6/16/26, Resident 1 was diagnosed with an unspecified fracture of the lower end of the left ulna (the outer bone in the forearm), and the fracture did not require surgery. Resident 1 was their own responsible party (made their own decisions). A review of Resident 1's Quarterly Minimum Data Set (MDS, a resident assessment tool), Section C, dated 5/13/26, indicated a Brief Interview for Mental Status (BIMS, an assessment that tested memory and thinking) was performed. Resident 1 scored a 15 out of 15, which indicated that Resident 1's ability to remember and think were intact. A review of Resident 1's Quarterly MDS, Section GG, dated 5/13/26, indicated that Resident 1 was dependent upon staff for showers, toileting hygiene (wiping or adjusting clothes) and to roll in bed from side-to-side. During a concurrent observation and interview on 6/23/26 at 2:00 pm, Resident 2 was observed sitting in a recliner, appeared to be in a pleasant mood and was smiling. Resident 1 indicated, on the evening of 6/6/26, two Certified Nursing Assistants (CNA) had provided Resident 1 with care and did not know their names. Resident 1 indicated the CNAs turned Resident 1 from side-to-side while in bed and when Resident 1 was being turned towards the left side of the bed, their left arm hit the bed cane (a metal grab bar that was attached to the bed). Resident 1 indicated that on 6/6/26, they were having difficulty with breathing, had been transported to the hospital late in the evening, and was ultimately admitted to the hospital. Resident 1 indicated, on 6/8/26, their breathing was better and she turned her focus to her left arm pain. Resident 1 reported to the hospital's Physician what had occurred when the CNAs had provided care on 6/6/26. Resident 1 indicated the hospital's Physician ordered an x-ray (a picture of the bones) and stated, My left ulna [wrist] is fractured. Resident 1 was observed to appear sad, was no longer smiling, and began to frown while shaking head from side to side while talking. Resident 1 indicated returning to the facility on 6/16/26 and had notified the Resident Care Manager (RCM) about the incident on 6/6/26 and was under the impression RCM would investigate the allegation. Resident 1 indicated, since the initial conversation with RCM, no one at the facility had come back to talk about the investigation results and wanted to know what had happened. A review of the hospital, Progress Note, dated 6/14/26, indicated the hospital's Physician reviewed Resident 1's x-ray from 6/8/26. The X-ray indicated that resident 1 had a minimally displaced distal ulnar shaft fracture (a minor crack or break at the end of the ulnar, in the wrist area). A review of Resident 1's, Progress Note, dated 6/17/26 and written by RCM, indicated that on 6/16/26, Resident 1 had returned to the facility from a hospital stay. RCM reviewed hospital records that included information about Resident 1's ulna fracture and allegations that it occurred in the facility while receiving care from the CNAs. The Progress Note indicated, RCM spoke with [Resident 1] about her [left] wrist fracture and asked her when and how she thought she hurt it. She said she was being provided care in bed by two CNAs and when rolled, her [left] hand hit her bed cane and started hurting after that. During an interview on 6/23/26 at 2:33 pm, RCM confirmed when a resident alleged that facility staff provided rough care or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sustained injuries during care, it would be viewed as an allegation of abuse, Admin would be notified immediately, and Admin would provide further instructions. RCM confirmed, on 6/16/26, when Resident 1 had returned to the facility, Resident 1 alleged sustaining a fracture to the left ulna while two CNAs had provided Resident 1 with care and that it occurred prior to Resident 1 going to the hospital. RCM indicated that due to Resident 1 not reporting the allegation on 6/6/26, and had waited until 6/16/26, and there was no documentation that supported Resident 1 had any pain prior to her hospitalization, RCM did not consider this an allegation of abuse or suspected abuse. RCM indicated that RCM had investigated Resident 1's statements and confirmed that RCM had not interviewed any possible witnesses, such as staff, the resident's roommate, and other residents cared for by the accused staff member. RCM indicated it was the Director of Staff's (DSD) responsibility to interview the CNAs. During an interview on 6/23/26 at 3:32 pm, the facility's Administrator (Admin) indicated that the RCM, the DSD, or the Admin could have interviewed the CNAs and that Admin had delegated the investigation to the RCM. Admin confirmed that allegation of abuse was not thoroughly investigated and the facility staff or Resident 1's roommate had not been interviewed.