

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Quartz Hill Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  2120 Benton Drive Redding, CA 96003	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859</b></p> <p>Based on observation, interview, and record review the facility failed to ensure the right to personal privacy for one of five sampled residents (Resident 1), when patient care was provided to Resident 1 without privacy being provided.</p> <p>This failure had the potential to cause distress and embarrassment for Resident 1 by having other residents watching and knowing her medical problems.</p> <p>Findings:</p> <p>A review of the facility's, policy titled Restorative Nursing Services, dated July 2017 indicated, 5. Restorative goals may include, but are note limited to supporting and assisting the resident in: c. Maintaining his/her dignity .</p> <p>A review of Resident 1's Admission Record , indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory and ability to make sound decisions), cognitive communication deficit (an impairment in thought organization, attention, memory, problem solving, and safety awareness), and diabetes (high sugar in the blood).</p> <p>During an observation on 1/17/25 at 12:08 PM in the dining room, Licensed Nurse A (LN A) entered the resident's dining room and checked Resident 1 ' s blood sugar by pricking her finger and using a glucometer (a devise used to measure blood sugar level) at the dining table, while other residents were at the table.</p> <p>During an observation on 1/17/25 at 12:13 PM in the dining room, LN A entered the dining room and gave Resident 1 an insulin (a biological product to treat blood sugar disease) shot at the dining table, with other residents at the table.</p> <p>During an interview on 1/23/25 at 11:32 AM, with the Infection Control Nurse (IP), the IP confirmed that checking blood sugar and giving insulin in the dining room did not meet the facility ' s standard practices for ensuring patient privacy and dignity.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49859</p> <p>Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation requirements were met in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> <li>1. Dietary Manager (DM) was not wearing a hair net in the kitchen.</li> <li>2. Food was not properly covered, labeled and dated.</li> </ol> <p>These failures created a potential risk for exposure to foodborne illnesses in a medically vulnerable population of 110 residents who received food prepared in the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During review of facility Policy &amp; Procedure (P&amp;P) titled Kitchen Cleaning Policy and Procedures, 4/20/23, the P&amp;P indicated food employees shall wear hair restraints such as hair nets.</li> </ol> <p>During concurrent observation and interview with the DM on 1/16/25 at 10:20 AM, the DM was not wearing a hair net in the kitchen. The DM confirmed that she should be wearing a hair net while in the kitchen.</p> <ol style="list-style-type: none"> <li>2. During review of facility Policy &amp; Procedure (P&amp;P) titled, Procedure for Refrigerated Storage, no date, the P&amp;P indicated food items will be covered, labeled, and dated.</li> </ol> <p>During concurrent observation and interview with DM on 1/16/25 at 10:23 AM, in the walk-in refrigerator the DM confirmed that there were two pans containing cranberry bars which were not covered, labeled, and dated.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49859</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control measures were adhered to when Licensed Nurse A (LN A) provided patient care in the dining room without following infection control policy and procedures. These failures had the potential to cause the spread of infection and disease to other residents in the dining room.</p> <p>Findings:</p> <p>A review of the facility's, policy titled, Infection Prevention and Control Program dated August 2016 indicated a. Important facets of infection prevention include: (2) instituting measures to avoid complications or dissemination (spread) and .adhere to proper techniques and procedures.</p> <p>A review of Resident 1's Admission Record , indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory and ability to make sound decisions), cognitive communication deficit (an impairment in thought organization, attention, memory, problem solving, and safety awareness), diabetes (high sugar in the blood).</p> <p>During an observation on 1/17/25 at 12:08 PM, in the dining room, LN A entered the dining room and checked Resident 1 ' s blood sugar by pricking her finger with a lancet (a small, sharp needle used to prick the skin to obtain a blood sample) and using a glucometer (a devise used to measure blood sugar level) at the table.</p> <p>During an observation on 1/17/25 at 12:13 PM, in the dining room, LN A entered the dining room and gave Resident 1 insulin (a biological product to treat blood sugar disease) using an insulin syringe (a short thin needle used to inject insulin into the body) at the table.</p> <p>During an interview on 1/23/25 at 11:32 AM, with the Infection Control Nurse (IP), the IP confirmed that checking blood sugar and giving insulin in the dining room did not meet the facility ' s infection control policy or standard practices.</p>