STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555356	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quartz Hill Post Acute	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility did not ensure that one of four residents sampled (Resident 1) did not get unnecessary medication when Resident 1 received a nicotine patch (a medicated adhesive patch that sticks to the skin to deliver a steady, controlled dose of nicotine into the bloodstream) when she was not a smoker.This failure caused Resident 1 to have diarrhea, be very unhappy and stressed and had an unwanted adverse effect to her physical and emotional well-being.Findings:Review of a facility policy titled, Adverse Consequences and Medication Errors revised June 2025 indicated 1. Review the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. 2. When a resident receives a new medication order, review: b. written diagnosis/indication supporting the use of the medication; g. documentation of the clinical rationale for using the medication.Review of a facility policy titled, Health, Medical Condition and Treatment Options, Informing Residents of revised November 2025 indicated that Every resident is informed of.treatment and/or care.Review of a facility policy titled, Reconciliation of Medications on Admission revised July 2017 indicated to review all the medications the resident was taking at the facility before going to the hospital and compare that list to any medications ordered or changed by the hospital to .determine if there are discrepancies/conflicts.for which there is no diagnosis or condition to support the use of the medication. The policy indicated that if discrepancies or conflicts are found that the facility should discuss with the resident or family and contact the attending physicianReview of a facility policy titled, Administering Medications revised April 2019 indicated that if a medication is believed to be inappropriate for a resident that the Attending Physician will be contacted.Review of a facility policy titled, Medication Regimen Reviews revised February 2025 indicated that the Medication Regimen Review (MRR) helps to identify irregularities such as medications being ordered that are not supported by medical evidence.Review of Resident 1's medical record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including long term use of antibiotics due to infection of her knees.Review of Resident 1's Minimum Data Set (MDS - a federally mandated assessment tool) section C, Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 4/24/26, completed by the MDS nurse, indicated a score of 15 indicating good decision-making ability.During a phone interview on 5/15/26 at 11:23 am, Resident 1 indicated that while she was a resident of the facility, she was given a nicotine patch but that she was not a smoker. Resident 1 indicated that after she returned to the facility on 4/27/26, from a hospital stay, she was not given any information about the nicotine patch when it was put on her body a few days later. Resident 1 indicated that the nicotine patch made her feel sick, have diarrhea, and that she was really unhappy and stressed about this happening while she was a resident of the facility. Resident 1 indicated that Charge Nurse B (CN B) told her that she was never supposed to get a nicotine patch and showed her a physician's order for her for nicotine patches from the hospital.During a concurrent interview and record review on 5/15/26 at 1:02 pm, with CN B of Resident 1's Medication Administration Record (MAR) for the months of April and May 2026, the physician's order dated 4/27/26 from the facility, and the physician's order from the hospital dated (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
	555356	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quartz Hill Post Acute	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/27/26, CN B confirmed that Resident 1 had orders for nicotine patches for smoking cessation (quitting smoking) and that Resident 1 had refused the nicotine patches on 4/28/26, 4/29/26, and 4/30/26. CN B indicated that she had not contacted the AP regarding Resident 1 refusing the nicotine patches. CN B indicated that she had taken care of Resident 1 before Resident 1 had been sent to the hospital from the facility on 4/24/26 and that Resident 1 was not a smoker, but that she returned from the hospital on 4/27/26 with a physician's order for nicotine patches. CN B indicated that she did not investigate why a resident who had no order for nicotine patches before leaving to go to the hospital came back to the facility a few days later with a physician's order for nicotine patches. CN B indicated that when Licensed Nurse (LN D) put a nicotine patch on Resident 1 and Resident 1 felt very sick, that Resident 1 was livid and that then CN B investigated and discovered that Resident 1 should not have gotten the nicotine patches because she was not a smoker and CN B indicated that she showed the physician's order for the nicotine patches from the hospital to Resident 1.During a concurrent interview and record review on 5/27/26 at 11:23 am, of Resident 1's records titled, Social Services Bundle assessment - WH V4 Sample - V2 dated 4/22/26 and 4/29/26 the Social Services Assistant (SSA) confirmed that both records indicated that Resident 1 was not a smoker.During an interview on 5/27/26 at 11:29 am, interview the Activities Director (AD) indicated that Resident 1 was not a smoker. AD indicated that if Resident 1 were a smoker the nursing staff would have notified her, or she would have observed Resident 1 in the smoking area and either of those would have triggered her to do a smoking assessment of Resident 1 which she did not do because Resident 1 was not a smoker.During a phone interview on 5/27/26 at 11:39 am, with the pharmacist (Pharm) indicated that if a person was not a smoker and was given a nicotine patch it would make their stomach upset with nausea and/or diarrhea. The Pharm indicated that a person who is not a smoker should not be given a nicotine patch. When asked if the pharmacist who reviewed Resident 1's medication should have noted that Resident 1 was not a smoker and should not get a nicotine patch, the Pharm responded that it was a physician's order.Review of Resident 1's record titled , Pharmacist's Report to Nursing - Medication Regimen Reviews performed between 4/28/26 and 4/29/26 indicated no reference to the physician's order for nicotine patches nor that Resident 1 was not a smoker.During an interview on 5/27/26 at 2:02 pm, Charge Nurse C (CN C) indicated that she had completed the medication reconciliation for Resident 1 upon her return to the facility from the hospital on 4/27/26. CN C indicated for medication reconciliation that she would review the physician's orders and cross reference with previous physician's orders and if there were any major changes she would reach out to the physician to find out more. CN C indicated that she was not aware whether or not if Resident 1 was a smoker and that she had never seen Resident 1 smoke. During an interview on 5/27/26 at 2:36 pm, the Director of Nursing (DON) acknowledged that Resident 1 was not a smoker. DON confirmed that Resident 1 should have received patient medication education. When asked about her expectations regarding medication reconciliation, DON indicated that when a resident returns to the facility from a hospital stay, that if a physician orders a medication for a resident, then the charge nurses would put it into the resident's physician's orders. DON confirmed that if a resident refuses a medication three times, then the nurse should notify the physician.