

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 02/13/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>51680</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure an allegation of abuse was timely reported to the state survey that involved 2 (Resident #12 and Resident #58) of 4 sampled residents reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 04/2021, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy specified, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Per the policy, 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>An Admission Record indicated the facility admitted Resident #12 on 10/17/2023. According to the Admission Record, the resident had a medical history that included diagnoses of muscle weakness, cognitive communication deficit, and arthritis.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/26/2025, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.</p> <p>An Admission Record indicated the facility admitted Resident #58 on 07/19/2023. According to the Admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, psychotic disorder, major depressive disorder, anxiety disorder, and cerebrovascular disease.</p> <p>A quarterly MDS, with an ARD of 01/28/2025, revealed Resident #58 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #12's Progress Notes dated 02/03/2025 at 10:26 PM, indicated at approximately 10:00 PM, a certified nursing assistant informed a nurse that Resident #12 reported that their roommate (Resident #58) had attacked them. Per the Progress Note, Resident #12 reported their roommate came over to their side of the room and attempted to forcefully take their call light out of their hand. The Progress Note revealed Resident #12 reported that their roommate scratched their left hand near the base of their thumb and index finger. According to the Progress Note, the nurse noted discoloration in the area that was beginning to bruise. The Progress Note indicated the Administrator and Director of Nursing (DON) were notified and Resident #12 was moved to another room in the facility for their safety.</p> <p>The Report of Suspected Dependent Adult/Elder Abuse, completed 02/03/2025, indicated the state survey agency received the abuse allegation on 02/04/2025 at 1:48 PM, which was greater than the two-hour time frame for reporting an allegation of abuse.</p> <p>During an interview on 02/12/2025 at 1:44 PM, the Administrator and DON both stated they were notified of the allegation of abuse that involved Resident #12 and Resident #58 by way of a text message on 02/03/2025. The Administrator stated he did not report the allegation of abuse to the state survey agency within two hours because there was no injury to the resident.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45555</p> <p>Based on interview, record review, and facility policy review, the facility failed to follow the physician's order for the use of an as-needed blood pressure medication for 1 (Resident #17) of 5 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>An Admission Record indicated the facility readmitted Resident #17 on 12/11/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of essential primary hypertension (high blood pressure).</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #17's care plan included a focus area initiated 06/14/2022 that indicated the resident had altered cardiovascular status related to hypertension. Interventions directed staff to give medications for hypertension, document response to medication and any side effects, and monitor blood pressure and notify the physician of any abnormal readings.</p> <p>Resident #17's Order Summary Report which included active orders as of 02/13/2025, revealed an order dated 12/11/2024, for clonidine hydrochloride (HCL) tablet 0.1 milligram (mg), give one table by mouth every six hours as needed for hypertension for a systolic blood pressure (SBP) greater than 150 millimeters of mercury (mmHg).</p> <p>Resident #17's Medication Administration Record [MAR], for 01/2025, revealed clonidine HCL 0.1 mg was not administered to the resident when their SBP was greater than 150 mmHg on 01/09/2025 at 2:00 AM, 01/12/2025, and 01/16/2025. Per the MAR, on 01/09/2025 at 2:00 AM, the resident had a blood pressure reading of 158/98 mmHg; on 01/12/2025 at 2:00 AM, the resident had a blood pressure reading of 190/87 mmHg; and on 01/16/2025 at 8:00 AM, the resident had a blood pressure reading of 158/90 mmHg.</p> <p>Resident #17's MAR for 02/2025, revealed clonidine HCL 0.1 mg was not administered to the resident when their SBP was greater than 150 mmHg on 02/07/2025. Per the MAR, on 02/07/2025 at 2:00 AM, the resident had a blood pressure reading of 154/77 mmHg.</p> <p>During an interview on 02/12/2025 at 12:16 PM, Licensed Vocational Nurse (LVN) #3 stated she did not recall administering Resident #17 clonidine, but she should have if the resident's SBP was greater than 150 mmHg.</p> <p>During an interview on 02/13/2025 at 11:16 AM, LVN #4 reviewed Resident #17's MAR and confirmed she should have administered clonidine to the resident on 01/16/2025 at 8:00 AM but could not remember if she did or not.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/13/2025 at 11:33 AM, LVN #5 stated if a medication was supposed to be given when a resident's blood pressure was high, then it should be administered and there should be documentation of the administration.</p> <p>During an interview on 02/13/2025 at 12:53 PM, the Director of Staff Development stated the nurses should follow the physician orders and give or hold medication according to the physician orders, and it should be documented.</p> <p>During an interview on 02/13/2025 at 1:15 PM, the Director of Nursing (DON) stated her expectation was that the nurses follow physician orders and parameters and document.</p> <p>During an interview on 02/13/2025 at 1:42 PM, the Administrator stated he deferred all nursing concerns to the DON, but stated the staff should follow the physician's orders.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>45555</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure there was a physician's order for the use of non-invasive mechanical ventilator for 1 (Resident #1) of 3 sampled residents reviewed for respiratory care.</p> <p>Findings included:</p> <p>A facility policy titled, CPAP/BiPAP [continuous positive air pressure/bilevel positive air pressure] Support, revised 03/2015, specified 3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP [positive end-expiratory pressure] pressure for the machine.</p> <p>An Admission Record indicated the facility admitted Resident #1 on 10/21/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of obstructive sleep apnea.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #1's care plan included a focus area revised 10/29/2024 that indicated the resident required respiratory therapy/pulmonary hygiene due to obstructive sleep apnea and was at risk for impairments with full lung expansion, shortness of breath, decreased oxygen saturation, and impaired functional mobility. Interventions directed staff to provide treatments per physician orders, monitor oxygen saturation before and after treatments, and notify the physician of any shortness of breath or oxygen saturation less than 90 percent.</p> <p>Resident #1's Respiratory Therapy Assessment, dated 10/30/2024, indicated the resident was educated on the use of the non-invasive mechanical ventilator, respiratory therapy, and treatment used for the maintenance of their respiratory status.</p> <p>Resident #1 Respiratory Therapy Daily Note, dated 11/13/2024, indicated the resident successfully used the non-invasive mechanical ventilator.</p> <p>Resident #1's Respiratory Therapy Weekly Progress Note, dated 11/15/2024, indicated the resident used a home non-invasive mechanical ventilator at night and as needed.</p> <p>Resident #1's Order Summary Report which contained active orders as of 02/11/2025, revealed no order for the use of a non-invasive mechanical ventilator.</p> <p>On 02/10/2025 at 10:03 AM, Resident #1 was observed lying in bed with a non-invasive mechanical ventilator on their nightstand.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/11/2025 at 1:54 PM, the Registered Nurse (RN) Respiratory Therapist (RT) stated residents should have orders for the use of a non-invasive mechanical ventilator that included the settings and when it should be applied. The RN RT stated Resident #1 was not currently on her case load, but the resident did use a non-invasive mechanical ventilator and should have an order for the use of it.</p> <p>During an interview on 02/12/2025 at 4:52 PM, Licensed Vocational Nurse (LVN) #3 stated residents needed to have orders to use a non-invasive mechanical ventilator that included the rate it was to be set at. LVN #3 stated Resident #1 used a non-invasive mechanical ventilator and was able to put on their own mask.</p> <p>During an interview on 02/13/2025 at 11:16 AM, LVN #4 stated if a resident used a non-invasive mechanical ventilator, they should have an order that included the settings, when to use it, and when to clean it. LVN #4 stated Resident #1 did use a non-invasive mechanical ventilator.</p> <p>During an interview on 02/13/2025 at 12:53 PM, the Director of Staff Development stated residents should have orders for the use of a non-invasive mechanical ventilator that included the settings, when to use, when to clean, and who to contact if it was not working to get it serviced.</p> <p>During an interview on 02/13/2025 at 1:15 PM, the Director of Nursing (DON) stated residents needed to have orders for the use of a non-invasive mechanical ventilator that included the application and removal, maintenance orders, and cleaning of the system.</p> <p>During an interview on 02/13/2025 at 1:42 PM, the Administrator deferred all nursing concerns to the DON, but that he expected everything to be in place for the use of respiratory equipment.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45555</p> <p>Based on observation, record review, interview, document review, and facility policy review, the facility failed to ensure a medication error rate of five percent or less. There were three errors out of 29 opportunities, which yielded a medication error rate of 10.34% for 2 (Resident #77 and Resident #75) of 4 residents observed for medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame and 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>1. The KwikPen pre-filled insulin pen user manual revised 07/2020, specified, Prime before each injection. Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensure that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.</p> <p>Resident #77's Order Summary Report that contained active orders as of 02/13/2025, revealed an order dated 03/22/2023, for multivitamin oral tablet, give one tablet by mouth one time a day for supplement. There was also an order dated 03/23/2023, for Humalog (insulin lispro) KwikPen subcutaneous solution pen-injector 100 units per milliliter, inject as per sliding scale with meals for diabetes mellitus.</p> <p>During medication administration observation on 02/12/2025 at 7:23 AM, Licensed Vocational Nurse (LVN) #1 administered medications to Resident #77, to include one multivitamin with mineral tablet. The surveyor noted LVN #1 did not prime the needle before he placed it on the insulin lispro kwikpen and turned the dose knob to two units.</p> <p>During an interview on 02/12/2025 at 12:45 PM, LVN #1 confirmed he administered a multivitamin with mineral tablet to the resident and stated technically he did not give the right medication, but he thought the order could be interchangeable. LVN #1 stated he did not know that the insulin pen needle needed to be primed.</p> <p>During an interview on 02/13/2025 at 12:53 PM, the Director of Staff Development (DSD) stated that when administering medications, the nurse should recognize the five rights, to include the right resident, route, medication, dose, and time, and should check the physician's order three times. The DSD stated the insulin pen needle should be primed with two units prior to dialing up the dose.</p> <p>During an interview on 02/13/2025 at 1:15 PM, the Director of Nursing (DON) stated the insulin pen needle should be primed with two units prior to use. Per the DON, the nurses should have followed the physician's orders to give the correct medication to the resident.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/13/2025 at 1:42 PM, the Administrator stated he deferred all nursing concerns to the DON.</p> <p>2. Resident #75's Order Summary Report for active orders as of 02/13/2025 included an order dated 10/14/2022, for senna-docusate sodium oral tablet 8.6-59 milligrams (mg), give two tablets by mouth one time a day for bowel care.</p> <p>During medication administration observation on 02/12/2024 at 7:47 AM, Licensed Vocational Nurse (LVN) #2 administered two senna 8.6 mg tablets to Resident #75.</p> <p>During an interview on 02/12/2025 at 12:43 PM, LVN #2 stated she gave plain senna tablets that did not contain docusate sodium to Resident #75. LVN #2 stated she should have checked the label of the medication with the order.</p> <p>During an interview on 02/13/2025 at 12:53 PM, the Director of Staff Development stated that when administering medications, the nurse should recognize the five rights, to include the right resident, route, medication, dose, and time, and should check the physician's order three times.</p> <p>During an interview on 02/13/2025 at 1:15 PM, the Director of Nursing (DON) stated that when administering medications, the nurse should review the physician's order and do the five rights with each medication three times. Per the DON, the nurses should have followed the physician's orders to give the correct medication to the resident.</p> <p>During an interview on 02/13/2025 at 1:42 PM, the Administrator stated he deferred all nursing concerns to the DON.</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>45555</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene and changed their gloves during the provision of incontinence care for 1 (Resident #109) of 1 sampled resident reviewed for urinary catheter.</p> <p>Findings included:</p> <p>An Admission Record indicated the facility admitted Resident #109 on 01/19/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/26/2025, revealed Resident #109 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene and always incontinent of bowel.</p> <p>Resident #109's care plan, included a focus area revised 02/12/2025, that indicated the resident had an alteration in elimination of bowel and bladder.</p> <p>On 02/12/2025 at 11:20 AM, the surveyor observed Licensed Vocational Nurse (LVN) #7 and Certified Nursing Assistant (CNA) #23 perform incontinence care on Resident #109. Once CNA #23 cleaned bowel from Resident #109's buttocks, she did not wash her hands or change her gloves, before she applied a clean incontinence brief underneath the resident. CNA #23 was also noted to touch the bed control of Resident #109's bed while wearing gloves she used to clean bowel from the resident's buttocks.</p> <p>During an interview on 02/12/2025 at 11:35 AM, CNA #23 stated she would change her gloves during incontinence care if the gloves became soiled. CNA #23 stated hand hygiene and gloves should be changed when she went from a dirty to clean task during the provision of care. CNA #23 acknowledged she did not perform hand hygiene or change her gloves when she provided care to Resident #109.</p> <p>During an interview on 02/12/2025 at 12:50 PM, LVN #7 stated hand hygiene and gloves should be changed when she went from a dirty area to a clean area during incontinence care. LVN #7 stated she and CNA #23 should have changed their gloves when the resident's incontinence brief was removed and before they placed a clean incontinence brief on the resident.</p> <p>During an interview on 02/13/2025 at 12:47 PM, the Infection Preventionist stated during incontinence care, staff should perform hand hygiene and change their gloves with each step.</p> <p>During an interview on 02/13/2025 at 12:52 PM, the Director of Staff Development stated gloves should be changed and hand hygiene should occur in between the dirty and clean tasks.</p> <p>During an interview on 02/13/2025 at 1:15 PM, the Director of Nursing (DON) stated that when staff provided incontinence care, they should perform hand hygiene, put on gloves, provide the care, and after the resident was cleaned, they should change their gloves and then replace the incontinence brief and clothing, remove their gloves, and perform hand hygiene.</p> <p>(continued on next page)</p>		

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