STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055003	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Rehabilitation & Wellness Center, LP	2353 Twenty Third St Eureka, CA 95501

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214 Based on interviews and record reviews, the facility failed to ensure one out of two sampled residents (Resident 1) received his showers twice a week as scheduled every Sundays and Wednesday. This failure reduced the facility ' s potential to mitigate Resident 1 ' s skin breakdown and reduced the potential for skin infection. Findings: A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE] with diagnoses which included Muscle Weakness, and Bipolar disorder (a mental health condition that causes extreme mood swings). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment tool) dated 4/9/24, indicated Resident 1 had a severely impaired cognition. Resident 1 ' s MDS dated [DATE] indicated he needed substantial assistance from staff during dressing and personal hygiene, but was dependent on staff during toileting, bathing or showering and putting on or taking off footwear. Resident 1 was incontinent (no control) of bowel function (eliminate feces from the body). A review of Resident 1 ' s shower sheet indicated that for 4/2024, Resident 1 only received 1 shower out of 8 scheduled showers on 4/19/24 and 1 bed bath (washing someone who is in bed) out of 8 scheduled showers on 4/5/24. A review of Resident 1 shower sheet for 5/2024 indicated Resident 1 received 0 out of 9 scheduled showers and only received 3 bed bath out of 9 scheduled showers on these dates: 5/1/24, 5/8/4 and 5/15/24. During an interview on 8/14/24 at 10:41 a.m., the Infection Preventionist (IP) stated it was the facility ' s policy to provide shower to the residents ' twice a week or more often as needed. The IP stated not providing showers regularly or as scheduled could result to missed skin impairment issues, impaired skin, wound infection and worsening of wounds. During an interview on 8/14/24 at 11:23 a.m., Certified Nursing Assistant I (CNA I) stated it was important to provide showers to the residents ' consistently, regularly, and as scheduled to ensure skin breakdown was not missed. (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: 055003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Eureka Rehabilitation & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2353 Twenty Third St Eureka, CA 95501	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 1:12 p.m., Licensed Nurse H (LN H) stated to prevent skin breakdown, showers should be provided twice a week to ensure skin remains free of skin breakdown. LN H stated not providing regular showers could lead to missed skin breakdown, development of new wound or PI and wound infection. During an interview on 8/14/24 at 1:28 p.m., LN F stated residents should receive showers twice a week regularly and as requested. LN F stated not receiving showers regularly could lead to missed skin impairment, worsening of wound or PI, wound infection, and development of PI. During a concurrent interview and record review on 8/14/24 at 2:05 p.m., the Director of Nursing (DON), Resident 1 ' s physician ' s order dated 5/30/24 was reviewed. The DON stated and confirmed Resident 1 was transferred to the emergency department (ED, a hospital room or area staffed and equipped for the reception and treatment of persons requiring immediate medical care) on 5/30/24 for wound evaluation, debridement (surgical removal of devitalized or contaminated tissue) and recommendations for IV antibiotics for sacral wound with Methicillin-resistant staphylococcus aureus (MRSA, a super bug, a form of contagious bacterial infection). The facility did not have a policy and procedure (P&P) specific for shower and ADL care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214 Based on observation, interviews and record review, the facility failed to ensure one of two sampled residents (Resident 1): 1. Received showers as scheduled every Sunday and Wednesday. 2. A treatment was requested and initiated once Resident 1 was noted with moisture associated skin damage (MASD, caused by prolonged exposure to various sources of moisture, including urine or stool) when he was admitted on [DATE]. 3. Treatments for pressure injury (PI, injury to skin and underlying tissue resulting from prolonged pressure on the skin) were consistently and regularly rendered per physician ' s order. 4. Resident 1 was being turned and repositioned (T&R, the movement of patients from one position to another to alleviate or redistribute any pressure) every 2 hours and more often as needed. 5. A care plan was developed (CP, a form that summarizes a resident ' s condition, current needs and treatment necessary for their care) to address Resident 1 ' s skin breakdown when he was initially admitted on [DATE]. 6. Licensed nurses (LNs) were accurately documenting the skin impairment and its location. These failures resulted in: A. Resident 1 developing a Stage 3 pressure injury on his sacrum (st 3 PI, full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) on 5/23/24, B. Resident 1 developing a wound infection on 5/30/24 which needed intravenous (IV, a way of giving a drug or other substance through a needle or tube inserted into a vein) antibiotics (medicines that fight bacterial infections) to be administered at the hospital, and C. Resident 1 developing a st 4 PI on his sacrum (a full thickness tissue loss with exposed bone, tendon, or muscle). Findings: A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Resident 1 ' s diagnoses included muscle weakness. A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 4/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 6 out of 15 indicating severely impaired cognition. Resident 1 ' s MDS dated [DATE] indicated he needed substantial assistance from staff during dressing and personal hygiene, but was dependent on staff during toileting, bathing or showering and putting on or taking off footwear. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1 ' s Clinical admitted d 4/5/24 and Weekly Skin Wound assessment dated [DATE] indicated Resident 1 ' s skin was intact with no identified skin impairment. 1. A review of Resident 1 ' s shower sheet (SS) indicated that for 4/2024, Resident 1 received 1 shower out of 8 scheduled showers on 4/19/24 and 1 bed bath on 4/5/24. Resident 1 ' s SS for 5/2024 indicated Resident 1 received 0 out of 9 scheduled showers and only received 3 bed baths: on 5/1/24, 5/8/4 and 5/15/24. 2. A review of Resident 1 ' s electronic treatment administration record (ETAR, an electronic record on what, when and who provided the treatment) for 4/2024, indicated no order to regularly treat Resident 1 ' s MASD that was noted upon admission. 3.The following treatment orders for Resident 1 were missing nursing signatures indicating the treatment was administered: a. 4/2024 ETAR: Sacral foam dressing to the tail bone area as needed and the treatment nurse to follow up for further assessment every 8 hours as needed for risk of pressure injury, dated 4/12/24: -no signatures from 4/12/24-4/26/24 b. 5/2024 ETAR: apply wound dressing to coccyx topically daily for PI and wound dressing to wound bed and peri wound (around the wound) area; apply skin protectant to intact surrounding skin and cover with foam dressing, dated 5/8/24: -no signatures 5/10/24, 5/11/24, 5/12/24 c. 7/2024 ETAR: apply wound dressing, apply topical wound treatment to peri wound, apply skin barrier film to surrounding intact tissue, cover with dressing daily when treating sacral/coccyx st 4 PU, dated 7/10/24: -no signatures on 7/11/24, 7/12/24, 7/17/24, 7/18/24 d. 7/2024 ETAR: apply topical ointment to peri wound area, apply skin barrier film to surrounding tissue, apply gauze to wound bed, cover with foam dressing every day for st 4 PI, dated 7/10/24: -no signatures on 7/11/24, 7/12/24, 7/17/24, 7/18/24. 4. A review of Resident 1 ' s ETAR for 6/2024 indicated an order for turning Resident 1 every 2 hours to offload pressure on buttocks, every shift, for wound care with a start date of 6/12/24, was missing a signature on 6/30/24 morning shift. Resident 1 ' s Telemedicine Wound Assessment and Plan showed the following: -5/16/24 indicated a st 2 PI on distal sacrum. -5/23/24 indicated a st 3 PI on distal sacrum with 50% slough and 50% eschar. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Eureka Rehabilitation & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE: 2353 Twenty Third St Eureka, CA 95501	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	-6/13/24 indicated Resident 1 was hospitalized for 2 weeks due to wound infection with Methicillin Resistant Staphylococcus Aureus (MRSA, a type of bacteria that is resistant to several antibiotics) and had increased the PI to st 4 post debridement (removal of damaged tissue or foreign objects from a wound). During an interview on 8/14/24 at 9:50 a.m., the Director of Nursing (DON) stated Resident 1 had an MASD and not a PI when he was admitted to the facility on [DATE]. The DON stated Resident 1 had acquired the PI while at the facility. During an observation on 8/14/24 at 10:00 a.m., Resident 1 was lying on his back. During an observation on 8/14/24 at 12:00 p.m. Resident 1 was lying on his back. During an observation on 8/14/24 at 2:03 p.m., Resident 1 was lying on his back. During an observation on 8/14/24 at 3:55 p.m., Resident 1 was still lying on his back. During an interview on 8/14/24 at 10:41 a.m., the Infection Preventionist stated residents should be turned and repositioned (T&R) every 2 hours or more often as needed to prevent PI to develop or to prevent an existing PI to worsen. The IP stated per nursing standards, anything that was not documented meant it did not happen. The IP stated missing nurse signature on the ETAR meant a treatment wasn ' t done as ordered and could result to wound infection, wound to worsen, and decreased quality of life. The IP stated staff should initiate and follow the skin breakdown CP to decrease the risk of developing PI or worsening of PI. The IP stated weekly skin sheets and skin assessments documentation should be accurate and complete because this will track residents ' wound on whether it was progressing or deteriorating so the nurses could request a treatment that would be more appropriate to treat the residents ' wound. The IP stated it was the facility ' s policy to provide shower to the residents ' twice a week or more often as needed. The IP stated not providing showers regularly or as scheduled could result to missed skin impairment, impaired skin, wound infection and worsening of wounds. During an interview on 8/14/24 at 11:23 a.m., Certified Nursing Assistant I (CNA I) stated residents should be T&R every 2 hours and more often as needed per facility policy to prevent skin breakdown and to prevent worsening of PI. CNA I stated it was important to follow the CP to provide safe care to the residents. CNA I stated residents ' were scheduled to receive showers twice a week or more often as needed. CNA I stated refusals should be documented. CNA I stated it was important to provide showers to the residents consistently, regularly and as scheduled to ensure skin breakdown was not missed, wound does not get infected, and PI does not worsen. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/14/24 at 1:12 p.m., Licensed Nurse H (LN H) stated to prevent skin breakdown, residents should be T&R every 2 hours and as needed and showers should be provided twice a week to ensure skin remains free of skin breakdown. LN H stated not T&R residents every 2 hours and not providing regular showers could lead to missed skin breakdown, development of new wound or PI and wound infection. LN H stated T&R every 2 hours or more often as needed does not really happen because there ' s just not enough staff to do this task consistently. LN H stated missing nurse signature on ETAR could mean treatment was not rendered which could also contribute to worsening of wound or PI and development of wound infection. LN H stated it was important to ensure an individualized CP was initiated and followed by staff because this would provide staff an idea on how to prevent a resident from acquiring further skin impairment and worsening of PI. LN H stated it was important to ensure nurses were accurately documenting location and type of wound the resident had to ensure accurate treatment and to ensure correct treatment was rendered on the correct site. During an interview on 8/14/24 at 1:28 p.m., LN F stated Resident 1 had pain on the left side of his back, so he needs a lot of help turning on his sides. LN F stated once a resident was noted to be a high risk for skin breakdown and if a resident was noted to have a st 3 PI, a low air loss mattress (LAL, a pressure redistributing mattress) should be in place right away. LN F stated LAL mattress help to ensure pressure was distributed evenly and could prevent skin breakdown or worsening of skin breakdown. LN F stated it was still recommended to turn and reposition residents as often as needed to prevent PI to develop or worsen. LN F stated Resident 1 was dependent on staff for provision of personal care. LN F stated it was important that skin CP be initiated, be individualized and followed for residents ' safety, to prevent further skin breakdown, and to prevent development of PI. LN F stated if there were missing signature on ETAR, it meant treatment was not provided and could lead to worsening of wounds, infection and development of new wounds. LN F stated residents should receive showers twice a week regularly and as requested. LN F stated not receiving showers regularly could lead to missed skin impairment, worsening of wound or PI, wound infection and development of PI. 5. During a concurrent interview and document review on 8/14/24 at 2:05 p.m., the DON stated Resident 1 ' s Braden Scale (PI risk evaluation) score on 4/12/24 was 15, meaning he was at mild risk for skin impairment due to decreased sensory perception, very moist skin requiring linen change once every shift, only ambulates occasionally and had limited mobility, inadequate nutritional intake and potential friction and shearing. On 4/29/24, Resident 1 ' s Braden Scale score was 13 indicating moderate risk for skin impairment due to the same reasons as above and additionally Resident 1 was chair bound. The DON verified that during this time, there was no skin CP initiated for Resident 1 based on the Braden scale risk evaluation, although a skin CP should have been initiated then. The DON stated the skin CP was initiated on 5/15/24. The DON stated on 5/21/24, Resident 1 ' s Braden Scale score was 12 indicating high risk for skin breakdown. The DON verified Resident 1 was transferred to the emergency department on 5/30/24 for wound evaluation, debridement (surgical removal of devitalized or contaminated tissue) and recommendations for IV antibiotics for sacral wound with Methicillin-resistant staphylococcus aureus (MRSA, a super bug, a form of contagious bacterial infection). The DON stated she was not sure how the wound got infected. 6. On 8/14/24 at 2:35 p.m., the DON verified the information on the weekly skin and wound assessment on these dates was inaccurate: 4/5/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 4/9/24- when there was no mention of Resident 1 ' s MASD. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	4/16/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 4/23/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 5/14/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 5/28/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 7/4/24, indicated Resident 1 ' s skin was intact with no identified skin impairment, however on the narrative, it indicated Resident 1 had a PI on his buttocks. 7/14/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. The DON verified there were conflicting documentation on the PI site between the weekly skin/wound assessment and the telemedicine wound assessment on these dates: 6/11/24, PI site was coccyx on weekly skin/wound assessment, however on 6/13/24, the telemedicine wound assessment indicated the PI site was the distal sacrum. During a concurrent interview and document review on 8/14/24 at 2:35 p.m., the DON stated Resident 1 had MASD upon admission and it was on 5/16/24 that Resident 1 was initially seen by the wound specialist via telemedicine and the wound on the sacrum was at st 2, measuring 2.8 centimeters (cm, measure of length) by 2.0 cm by 0.2 cm. On 5/23/24, the st 2 PI on the sacrum worsened to st 3 PI measuring 3.5 cm by 2.5 cm with 50 percent slough, 50% eschar. The DON stated the deterioration of the wound probably prompted the doctor to order culture and sensitivity of the wound. The DON stated it was important nurses were documenting accurately and consistently to improve outcome for resident with wounds. The DON stated inaccurate documentation raises the issue if nurses were even looking at the wound, assessing the resident or if the nurses were assessing the residents with wound appropriately. The DON stated inaccurate wound documentations could result to inadequate patient care. During a concurrent interview and record review on 8/14/24 at 3:26 p.m., the DON verified there was no treatment order for Resident 1 ' s MASD when he was admitted on [DATE]. The DON stated the ETAR dated 5/2024 indicated the earliest treatment to the coccyx was initiated on 5/8/24. The DON stated the treatment should have been to the sacrum, which could create confusion. The DON stated nurses need further education on the correct anatomical position. The DON stated if a PI had no treatment in place, it could lead to wound to deteriorate and wound infection. The DON verified Resident 1 did not have an at risk for skin breakdown CP, and had no MASD CP. The DON verified Resident 1 did not have a PI CP created until 5/15/24. The DON stated there should absolutely be one created for Resident 1 so the nurses and CNAs could follow the plan and prevent further deterioration of wound. The DON stated not having a CP in place could contribute to wound deterioration. The DON stated the facility discovered the st 3 PI on Resident 1 ' s distal sacrum on 5/22/24 and should have transitioned to an LAL mattress then, however it was not until 5/28/24 that Resident 1 transitioned to a LAL mattress. When asked about the delay, the DON stated she was not sure why the delay. The DON stated the delay could have been detrimental to Resident 1 ' s wound healing. The DON stated residents on LAL mattress should still be T&R. The DON stated Resident 1 would still need to be T&R every 2 hours. The DON stated T&R every 2 hours was important to ensure Resident 1 ' s wound does not deteriorate and to prevent development of new PI or skin issues. (continued on next page)

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Eureka Rehabilitation & Wellness Center, LP	2353 Twenty Third St Eureka, CA 95501

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility did not have a policy and procedure (P&P) specific for T&R, shower and ADL care. A review of the facility ' s P&P titled Pressure Injury Prevention, revised 3/30/24, the P&P indicated, .to develop a plan of care based on the residents ' risk factors, implement interventions identified in the plan of care such as T&R . A review of the facility ' s P&P titled Pressure Ulcer Management, revised 1/1/2012, the P&P indicated a resident with pressure ulcer will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing .CNAs will complete body checks on residents ' shower days and report unusual findings to the Licensed Nurse . A review of the facility ' s P&P titled Skin Integrity Management, revised 10/26/23, the P&P indicated, . treatment administered will be documented in the residents ' medical record The Cleveland Clinic published on 4/27/2020 on skin care where Dr. Khetarpal says We come in contact with thousands of allergens every day. Showering rinses off those allergens, as well as bacteria and viruses. Healthline published on 1/29/2019 on skin care: Poor hygiene or infrequent showers can cause a buildup of dead skin cells, dirt, and sweat on your skin. Showering too little can also trigger an imbalance of good and bad bacteria on your skin and too much bad bacteria on your skin also puts you at risk for skin infections.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40214

Based on interviews and record reviews, the facility failed to:

1.recognize signs and symptoms of Urinary Tract Infection (UTI, a bacterial infection of the bladder and associated structures) and Sepsis (your body's extreme reaction to an infection) for one out of 2 sampled residents (Resident 1).

This failure resulted to Resident 1 to fall on 4/25/24 which caused:

A.skin tear(traumatic wounds that may result from a variety of mechanical forces such as shearing - a horizontal force that causes the bony prominence to move across the tissue as the skin is held in place, or frictional forces- the rubbing of one body against another , including blunt trauma, falls, poor handling, equipment injury) on his right elbow measuring 6.4 centimeters (cm, a measure of length) and;

B.an acute comminuted right femoral intertrochanteric fracture (a comminuted fracture occurs when your bone breaks into more than three pieces, intertrochanteric fracture is when a hip breaks between the bumpy parts at the top of the thigh bone).;

C.Due to this fracture, Resident 1 had undergone a short intermedullary nail fixation (a surgical procedure used to internally set and stabilize fractured bones) of the right hip intertrochanteric fracture on 4/25/24.

Findings:

A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE].Resident 1 ' s diagnoses included Muscle Weakness, Hyperlipidemia (HLP, too many lipids-fats in your blood) and Bipolar disorder (a mental health condition that causes extreme mood swings). A review of Resident 1 ' s Minimum Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 4/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 6 indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1 ' s MDS assessment dated [DATE] indicated he needed substantial assistance from staff during dressing and personal hygiene, but was dependent on staff during toileting, bathing or showering and putting on or taking off footwear.

A review of Resident 1 Hospitalist Discharge Summary (DC summary, a narrative document for communicating clinical information about what happened to the patient in the hospital) dated 4/29/24 indicated Resident 1 presented to the emergency department (ED, the part of a hospital where people go when they are seriously ill or injured and need treatment) on 4/25/24 after a fall from the bed and altered mentation. The DC summary active hospital problems include Sepsis secondary to UTI and Acute Comminuted fracture of the right femur. The DC summary also indicated Resident 1 had undergone a short intermedullary nail fixation of the right hip intertrochanteric fracture on 4/25/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of bilateral (both) hip X-Ray (XR, produces images of the hip) result done on 4/25/24, indicated the hip XR impression was acute comminuted right femoral intertrochanteric fracture. A review of Resident 1 Fall Risk Evaluation (assessment that checks your risk of falling) dated 4/5/24 indicated Resident 1 was a fall risk due to intermittent confusion, ambulatory and incontinence, poor vision, had a change in condition and was recently hospitalized and had balance problem while standing and walking. A review of Resident 1 ' s at risk for fall care plan (CP, specifies your health care and support needs and outlines how your provider will meet your requirements) dated 4/5/24 interventions included if a resident was a fall risk to initiate fall risk precaution, however there were no specific interventions listed to prevent or decrease Resident 1 likelihood of falling. A review of the electronic medical record, nursing progress note, laboratory test results of Resident 1 with the Director of Nursing on 8/14/24 at 1:55 p.m., indicated the Licensed Nurses (LN) were not monitoring Resident 1 for signs and symptoms of UTI and Sepsis and there was no laboratory test requested by staff to check Resident 1 for UTI. During an interview on 8/13/24 at 3:37 p.m., LN E stated UTI and Sepsis result to confusion so residents were at a higher risk of falling. LN E stated falls increased the risk for pain, hospitalization , and fractures. During an interview on 8/13/24 at 4:23 p.m., LN F stated Resident 1 was a high fall risk. During a concurrent interview and nursing progress note dated 4/21/24 to 4/25/24, hospital discharge summary note dated 4/29/24, hip XR result dated 4/25/24 on 8/14/24 at 1:55 p.m., the DON verified Resident 1 had a femoral fracture after his fall on 4/25/24. The DON stated the cause of fall was sepsis secondary to UTI. The DON verified Resident 1 had no laboratory test to check for UTI and had no change of condition or nursing progress note that Resident 1 was being monitored for signs and symptoms of UTI or Sepsis prior to Resident 1 ' s fall on 4/25/24. The DON stated the nurses missed the UTI, left untreated, had worsened to sepsis, which probably caused Resident 1 to fall. A review of the facility ' s policy and procedure (P&P) titled Fall Management Program revised 3/13/21, the P&P indicated it was the policy of the facility, . to provide residents a safe environment that minimizes complications associated with falls .a licensed nurse will conduct a new fall risk upon identification of a significant change of condition and as needed . the Interdisciplinary Team (IDT, group of professional and direct care staff that have primary responsibility for the development of care plan for an individual receiving services) and/or the licensed nurse will develop a care plan according to the identified risk factors and root cause(s). The facility did not have a P&P specific for UTI and Sepsis .

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NAME OF PROVIDER OR SUPPLIER Eureka Rehabilitation & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2353 Twenty Third St Eureka, CA 95501	

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214 Based on interviews and record reviews, the facility failed to ensure there were adequate staff when: 1.Four out of four residents (Residents 2, 3, 4 and 5) complained the facility was short staffed. 2. Six out of six staff reported the facility was short staffed. 3. Based on the census (official periodic count of a population) and Direct Care Service Hours Per Patient Day (DHPPD, the minimum number of actual nursing hours performed by nursing staff per patient day), the facility did not meet the actual DHPPD for 8 out of 10 days from 4/21/24 up to 4/30/24 on these dates: 4/21/24 at 2.68, 4/22/24 at 2.63, 4/23/24 at 3.30, 4/25/24 at 3.43, 4/26/24 at 3.08, 4/27/24 at 3.35, 4/28/24 at 2.93, 4/29/24 at 2.99. These failures resulted in 1A. Resident 2 stated staff was always in a rush to complete their task and feeling unsafe that nobody could come to help her if she needed help in case of a medical emergency. 1B. Resident 3 feeling frustrated she had to wait for up to an hour for staff to answer their call light. 1C. Resident 4 feeling upset she had to wait for a long time for staff to answer their call light. 1D. Resident 5 stated the facility should [RV1] staff more so that they could provide prompt care to the residents and not always be in a rush to complete their task, feeling upset she had to wait for a long time for staff to answer her call light and feeling scared staff would not get to her on time in case of a medical emergency. Findings: A review of Resident 2 ' s face sheet (demographics) indicated Resident 2 was admitted on [DATE]. Resident 2 ' s diagnoses included muscle weakness, Chronic Pain Syndrome (CPS, long standing pain that persists beyond the usual recovery period) and General Anxiety disorder (GAD, persistent worrying or anxiety about a number of areas that are out of proportion to the impact of the events. A review of Resident 2 ' s Minimum Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents), [RV2] Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) dated 5/31/24 score was 15 indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 2 required assistance from staff during provision of personal care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3 ' s face sheet indicated Resident 3 was admitted on [DATE]. Resident 3 ' s diagnoses included muscle weakness, Muscle Dystrophy (a group of diseases that cause progressive weakness and loss of muscle mass). A review of Resident 3 ' s MDS BIMS dated 6/13/14 score was 15 indicating intact cognition. Resident 3 required assistance from staff during provision of personal care. A review of Resident 4 ' s face sheet indicated Resident 4 was admitted on [DATE]. Resident 4 ' s diagnoses included Multiple Sclerosis (MS, condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance), Hyperlipidemia (HLP, too many lipids-fats in your blood), and Essential Hypertension (HTN, high blood pressure). A review of Resident 4 ' s MDS BIMS dated 3/15/24 score was 10 indicating moderately impaired cognition. Resident 4 required assistance from staff during provision of personal care. A review of Resident 5 ' s face sheet indicated Resident 5 was admitted on [DATE]. Resident 5 ' s diagnoses included CPS, HLP, and HTN. A review of Resident 5 ' s MDS BIMS dated 8/18/24 score was 15 indicating intact cognition. Resident 5 required assistance from staff during provision of personal care. During an interview on 8/13/24 at 1:25 p.m. Certified Nursing assistant A (CNA A) and staffing coordinator (SC) stated she does not really use any guideline when staffing but rather she just uses her brain and personal judgement when staffing the facility. CNA A stated the facility aimed to reach the 3.5/2.4-mark PPD. CNA A stated she was aware the facility was not meeting this PPD mark which meant they were short staffed. CNA A stated that short staffing put residents ' safety at risk and could result to accidents, injury, falls and elopements. During an interview on 8/13/24 at 2:20 p.m., CNA C stated the facility was short staffed[RV3] (not enough staff were on the floor to care for the residents at the facility). CNA C stated short staffing was a safety risk for the residents. CNA C stated short staffing increased the residents ' risk for falls, injuries, and elopement. CNA C stated short staffing made it difficult for staff to complete their task and to provide safe care to the residents. During an interview on 8/13/ at 2:43 p.m., CNA G stated the facility was short staffed[RV4] . CNA G stated short staffing made it difficult to complete their task. CNA G stated short staffing was a safety risk for the residents. CNA G stated short staffing could lead to falls, accidents, not providing quality care and care not being provided at all. CNA G stated a lot of falls could have been prevented if the facility had adequate staff. During an interview on 8/13/24 at 3:37 p.m., Licensed Nurse (LN) E stated the facility was not adequately staffed (not enough staff were on the floor to care for the residents in the facility).[RV5] LN E stated it was dangerous to not have enough staff because it increased the residents ' risk for falls, accidents, injuries, and elopements. During an interview on 8/13/24 at 3:56 p.m. Resident 2 stated the facility was short staffed. Resident 2 stated staff would always be in a rush to complete their task. Resident 2 stated staff would answer call light between 30 minutes up to an hour because the facility did not have enough staff to care for the residents at the facility. Resident 2 stated she felt unsafe that nobody would come to help her if she needed help in case of a medical emergency. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/24 at 4:23 p.m., LN F stated the facility was short staffed. LN F stated sometimes each CNAs have up to 15 residents to care for in the morning shift. LN F stated this was hard because most resident at the facility were dependent on staff and requires 2 persons assist. LN F stated weekend staffing were harder. LN F stated short staffing poses a safety risk for the residents as it could lead to increased risk for falls, late response to call lights, accidents, and skin injuries. During an interview on 8/13/24 at 4:12 p.m., Resident 3 stated the facility was short staffed. Resident 3 stated the staff would often tell her they were short staffed when she asked them why it took them a long time to answer her call light. Resident 3 stated the facility need to staff more. Resident 3 stated it was frustrating to be waiting for up to an hour for staff to answer their call light. During an interview on 8/13/24 4:22 p.m., Resident 4 stated the facility was short staffed. Resident 4 stated staff would tell her that sometimes they had up to 15 residents to care for on their shift. Resident 4 stated she wished the facility would staff more so they could provide prompt care to the residents and not always be in a rush to complete their task. Resident 4 stated it was upsetting to be waiting for a long time for staff to answer their call light. Resident 4 stated staff were not prompt in answering their call for help. Resident 4 stated it was because the facility was short staffed. During an interview on 8/13/24 at 5:24 p.m., Resident 5 stated the facility was short staffed. Resident 5 stated they had to wait for a long time before staff answers their call light. Resident 5 stated staff would tell them they could not answer call light right away because they were short staffed. Resident 5 stated she felt frustrated and sometimes upset when she had to wait for a long time for staff to answer her call light. Resident 5 stated she also felt scared staff would not get to her on time in case of a medical emergency. During an interview on 8/14/24 at 1:12 p.m., LN H stated the facility was understaffed. LN H stated each nurse had about 31 residents under their care, and CNAs had about 15 residents each if they only have 2 CNAs on their wing. LN H stated majority of the residents were needing 2 persons assist, were dependent on staff for feeding and requires constant supervision for their safety. During an interview on 8/14/24 at 2:03 p.m., the Director of Nursing (DON) stated she was aware the facility was short staffed and was worried residents would not receive the care that they need. A review of the Census and Direct Care Service Hours Per Patient Day (DHPPD) indicated the Actual DHPPD was not met for 8 out of 10 days from 4/21/24 up to 4/30/24 on these dates: 4/21/24 at 2.68, 4/22/24 at 2.63, 4/23/24 at 3.30, 4/25/24 at 3.43, 4/26/24 at 3.08, 4/27/24 at 3.35, 4/28/24 at 2.93, 4/29/24 at 2.99. A review of the facility ' s policy and procedure (P&P) titled Nursing Department- Staffing, Scheduling & Postings, revised 7/2018, the P&P indicated, .each facility will employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per patient day .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Rehabilitation & Wellness Center, LP	2353 Twenty Third St Eureka, CA 95501

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214 Based on interviews and record reviews, the facility failed to ensure licensed nurses have the competencies necessary in providing care for the residents when: 1.Licensed Nurses (LNs) were not accurately documenting the skin impairment and its location for one out of two sampled residents (Resident 1). 2. LNs failed to recognize signs and symptoms of Urinary Tract Infection (UTI, a bacterial infection of the bladder and associated structures) and Sepsis (your body's extreme reaction to an infection) for one out of 2 sampled residents (Resident 1). These failures: 1A. resulted to inaccurate documentation as to the exact location and status of Resident 1 ' s pressure injury (PI, breakdown of skin integrity due to pressure). 2B. resulted to Resident 1 ' s fall on 4/25/24 causing an acute comminuted right femoral intertrochanteric fracture (a comminuted fracture occurs when your bone breaks into more than three pieces, intertrochanteric fracture is when a hip breaks between the bumpy parts at the top of the thigh bone). 2C. Dueto this fracture, Resident 1 had undergone a short intermedullary nail fixation (a surgical procedure used to internally set and stabilize fractured bones) of the right hip intertrochanteric fracture on 4/25/24. Findings: A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Resident 1 ' s diagnoses included Muscle Weakness, Hyperlipidemia (HLP, too many lipids-fats in your blood) and Bipolar disorder (a mental health condition that causes extreme mood swings). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents)[VR3] dated 4/9/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 6 indicating severely impaired cognition. 1. During an interview on 8/14/24 at 10:41 a.m., the Infection Preventionist (IP) stated weekly skin sheets and skin assessments documentation should be accurate and complete because this will track residents ' wound on whether it was progressing or deteriorating and so the nurses could request a treatment that would be more appropriate to treat the residents ' wound. The IP stated inaccurate wound documentation results to poor communication between staff and the doctor and was a potential for medical error. During an interview on 8/14/24 at 1:12 p.m., Licensed Nurse H (LN H) stated it was important to ensure nurses were accurately documenting location and type of wound the resident have to ensure accurate treatment and to ensure correct treatment was rendered on the correct site. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview , weekly skin/wound assessment and telemedicine wound assessment and plan record review on 8/14/24 at 2:35 p.m., the DON, while reviewing the weekly skin/wound assessment and telemedicine wound assessment and plan, stated, it was important nurses were documenting accurately and consistently to improve outcome for resident with wounds. The DON stated inaccurate documentation raises the issue if nurses were even looking at the wound, assessing the resident or if the nurses were assessing the residents with wound appropriately. The DON stated inaccurate wound documentations could result to inadequate patient care. During a concurrent interview, weekly skin/wound assessment and telemedicine wound assessment and plan record review on 8/14/24 at 2:35 p.m., the DON verified the information on the weekly skin and wound assessment on these dates were inaccurate : 4/5/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 4/9/24- when there was no mention of Resident 1 ' s MASD. 4/16/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 4/23/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 5/14/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 5/28/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. 7/4/24, indicated Resident 1 ' s skin was intact with no identified skin impairment, however on the narrative portion of the weekly skin/wound assessment, it indicated Resident 1 had a PI on his buttocks. 7/14/24, indicated Resident 1 ' s skin was intact with no identified skin impairment. The DON verified there were inaccurate documentation the PI site between the weekly skin/wound assessment and the telemedicine wound assessment on these dates: 6/11/24, PI site was coccyx on weekly skin/wound assessment, however on 6/13/24, the telemedicine wound assessment indicated the PI site was the distal sacrum. During a concurrent interview, and review of electronic treatment administration record (ETAR, digital version that tracks which treatment was rendered to a resident) dated 4/2024 and 5/2024 record review on 8/14/24 at 3:26 p.m., with the DON, the DON verified the ETAR dated 5/2024 indicated the earliest treatment to the coccyx was initiated on 5/8/24. The DON stated the treatment should have been to the sacrum. The DON stated the nurses need further education on the correct anatomical position. 2. A review of the electronic medical record, nursing progress note, laboratory test results of Resident 1 with the Director of Nursing, indicated the Licensed Nurses (LN) were not monitoring Resident 1 for signs and symptoms of UTI and Sepsis and there was no laboratory test requested by staff to check Resident 1 for UTI. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the DON, nursing progress note dated 4/21/24 to 4/25/24, hospital discharge summary note dated 4/29/24, hip XR result dated 4/25/24 on 8/14/24 at 1:55 p.m. were reviewed. The DON verified Resident 1 had a femoral fracture after his fall on 4/25/24. The DON stated the cause of fall was sepsis secondary to UTI. The DON verified Resident 1 had no laboratory test to check for UTI and had no change of condition or nursing progress note that Resident 1 was being monitored for signs and symptoms of UTI or Sepsis prior to Resident 1 ' s fall on 4/25/24. The DON stated the nurses missed the UTI, left untreated, had worsened to sepsis, which caused Resident 1 to fall. During an interview on 8/14/24 at 10:41 a.m., the Infection Preventionist (IP) stated Sepsis occurs when there ' s bacteria and you don ' t catch it early enough to treat it with antibiotic and the infection worsen. The IP stated untreated UTI could result to sepsis could be a life-threatening condition. The IP stated sepsis and UTI increased the risk for falls, injuries, and hospitalization . When asked, the facility did not provide a policy specific for resident care with UTI and Sepsis. The [NAME] Journal titled Management of Sepsis and Septic Shock (a severe drop in blood pressure, progression to septic shock raises the risk of death, focusing on sepsis identification, medical emergency, necessitating urgent assessment and treatment. When asked, the facility did not provide a specific policy on assessment and accurate documentation. The American Nurses Association (ANA, national professional organization that promotes and protects the welfare of nurses in their work settings) indicated these principles for nursing documentation: clear, accurate, and accessible documentation as an essential element of safe, quality, and evidence-based nursing practice.