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	08/26/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nursing services that met professional standards of quality for three residents (Resident 1, Resident 2, Resident 3) out of a sampled seven residents when licensed nurses did not:1. Initiate a care plan that included a recent occurrence of resident-to-resident abuse for Resident 1 and Resident 2; and,2. Conduct 72-hour monitoring following Resident 3's fall.These failures had the potential to place Resident 1, Resident 2, and Resident 3 at risk for serious harm, health deterioration and a loss of quality of life.1.A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with Alzheimer's Disease (a disease characterized by progressive decline in mental abilities).A review of Resident 1's care plans indicated the following:- On 10/25/24 a care plan was initiated and indicated Resident 1 had the potential to be physically aggressive related to dementia (a decline in memory, reasoning, thinking and judgement). Staff were expected to implement interventions which included monitoring Resident 1 for signs and symptoms of posing a danger to himself or others. -On 5/19/25 a care plan was initiated and indicated Resident 1 had a behavior problem with spontaneous short bursts of anger which was evidenced by striking out at other residents. Staff were expected to intervene as necessary to protect safety and rights of others and to de-escalate when behavior is triggered.A review of Resident 1's Minimum Data Set (MDS-a federally mandated assessment tool), dated 6/2/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- an assessment used to measure cognition (a person's ability to process information and understanding)) score of 6 which indicated severe impairment. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis (paralysis or weakness on one side of the body) following other non-traumatic intracranial hemorrhage (bleeding within the skull) affecting left non-dominant side. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 3 which indicated severe impairment. A review of Resident 1's Progress Notes dated 8/12/25 at 8 p.m., indicated Resident 1 was standing in the corner of the hallway near the double doors.[Resident 1] grabbed [Resident 2's] arm and it provoked or possible (sic) scared [Resident 2]. During an interview on 8/26/25 at 10:05 a.m., Licensed Nurse 1 (LN 1) stated she witnessed the occurrence between Resident 1 and Resident 2. She stated Resident 2 was propelling himself down the hallway near the double door entrance while Resident 1 was standing in the corner by the entrance. As Resident 2 approached the entrance, Resident 1 grabbed Resident 2's arm, scaring Resident 2. LN 1 immediately separated Resident 1 and Resident 2. During an interview on 8/26/25 at 12:10 p.m., the Director of Nursing (DON) and the Director of Staff Development (DSD) stated that staff should have created or edited care plans for Residents 1 and 2 following their occurrence. The DON and DSD confirmed no care plans were ever created or updated to reflect the occurrence; therefore, staff were provided with no guidance on appropriate interventions. 2. A review of Resident 3's admission Record indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of Metabolic Encephalopathy (a condition in which the brain function is impaired due to chemical imbalances in the body, usually resulting from liver or kidney failure). A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had a BIMS score of 0 which indicated severe impairment. A review of Resident 3's Progress Notes dated 8/15/25 at 10:03 a.m., indicated Resident 3 was found on the bathroom floor, unable to state what happened when questioned by facility staff. Resident 3 was sent to the Emergency Department for evaluation and returned to the facility with a report of no injuries. During an interview on 8/26/25, at 4:10 p.m., the DON and DSD stated the a monitoring period of 72 hours was expected to be completed and documented by licensed staff for any resident with a change in condition, after the resident was evaluated and safe. The DON and DSD confirmed Resident 3 was missing 48 hours of monitoring for dates of 8/16/25 and 8/17/25. A review of facility policy titled Change in Condition, dated 8/25/22, indicated, The Licensed Nurse will document the following.update the care plan to reflect the resident's current status .A licensed nurse will document each shift for at least seventy-two (72) hours when there is a change in the residents condition.