

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
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 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to implement measures to prevent an avoidable fall for one resident (Resident 1) for a census of 71 residents, when Resident 1 was transferred from his bed to a chair using a Hoyer lift (a brand of portable patient lift (mechanical lift) designed to help caregivers safely transfer individuals with limited mobility between beds, chairs, and wheelchairs) with a one person assist and a frayed (material that is worn or unraveled at the edges) Hoyer lift sling (the crucial fabric interface that attaches a patient to a mechanical or hydraulic lift for safe transferring). This failure resulted in Resident 1 falling from the Hoyer lift and sustaining left rib fractures, a transverse process fracture (a break in the wing-like bony projections on the sides of the vertebrae (the bones that make up the spine), and a hemothorax (the accumulation of blood in the pleural space between the lungs and chest wall). These injuries caused the resident significant pain and distress. A review of Resident 1's admission record indicated that the resident was initially admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD-a progressive, long-term lung disease that makes breathing difficult by restricting airflow), muscle weakness, and the presence of an unspecified artificial hip joint (indicating the resident had a hip replacement, though the side-left or right-was not specified). A review of Resident 1's Minimum Data Set (MDS- a federally mandated clinical assessment tool used in Medicare and Medicaid-certified nursing homes and skilled nursing facilities), dated 5/20/26 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a standardized assessment used in nursing homes to evaluate memory, attention, and orientation). The resident scored 14, which indicates cognition is intact. The BIMS scoring range is 0 to 15, with 13-15 indicating intact cognition, 8-12 indicating moderate impairment, and 0-7 indicating severe impairment. A review of Resident 1's MDS Section GG- Functional Abilities dated 3/31/26 indicated Resident 1 had limited mobility and was dependent on two-person assistance for bed to chair transfers, lying-to-sitting on side of bed, toileting, and tub/shower transfers. A review of Resident 1's Change In Condition (CIC) form dated 5/10/26, indicated Resident 1 fell from the Hoyer lift on 5/10/26, when the Hoyer sling straps broke. The resident had pain in the left side, neurological checks (neuro checks; a clinical evaluation used to assess the function of the brain, spinal cord, and nervous system) were monitored, and the resident was transferred to the hospital by Emergency Medical Services (EMS). During a concurrent observation and interview on 6/4/26 at 10 a.m., Resident 2 was transferred from the bed to a wheelchair with two-person assistance from Certified Nursing Assistant (CNA) 2 and CNA 3 in Resident 2's room. CNA 2 and CNA 3 positioned a Hoyer lift sling under the resident, and Resident 2 was lifted and transferred to the wheelchair, with CNA 3 providing additional support to ensure a safe transfer. The sling used for Resident 2 appeared to be in new condition. During an interview, CNA 2 stated that all residents require a two-person assist when using the Hoyer (mechanical) lift. When asked about the condition of the slings used at the time of Resident 1's fall, CNA 2 stated the slings were old and worn, likely due to frequent laundering. CNA 2 further stated that, to their knowledge, staff had not reported the condition of the slings to management. CNA 2 also stated that all staff (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	received in-service training on the use and management of the Hoyer lift and slings, and that residents are measured by weight to ensure the correct sling size is used. CNA 2 reported as of May 22, 2026, the facility had replaced all the Hoyer slings with new ones. During an interview on 6/4/26 at 11 a.m., the Director of Staff Development (DSD) stated that transferring or weighing a resident with the mechanical lift requires a two-person assistance. The DSD explained that all staff who use the Hoyer lift are responsible for checking the lift's function and the integrity of the sling. Sling sizes are listed on a chart, and each resident is measured by weight to ensure the correct size is used. When asked about the slings used prior to the current incident, the DSD stated they were old, worn, and not well maintained, and noted that the facility purchased and received all new slings on May 22, 2026. The DSD acknowledged that CNA 5 was alone when transferring Resident 1 on 5/10/26 and should have had another staff member assisting. The DSD reported that in-service training and retraining on the use of the Hoyer lift and sling assessment were conducted for all staff between May 10, 2026 and May 15, 2026. During an interview on 6/4/26 at 1:45 p.m., Resident 1 was lying in bed with the head of the bed elevated. The resident stated on 5/10/26 (Mother's Day), he was preparing to go to church when someone, not aware of what he was doing, placed him in the Hoyer lift. He reported that one of the straps broke, causing him to fall to the floor. Resident 1 stated he was injured and experienced pain in his ribs, chest, tail bone, and the muscles on the left side of his chest. He confirmed that CNA 5 transferred him alone. When asked if he had pain Resident 1 stated Yes, I still have pain. The nurses gave me pain medicine, but I need something stronger. During a telephone interview on 6/9/26 at 9:40 a.m., Licensed Staff (LS) 4 stated on 5/10/26 she heard yelling coming from room [ROOM NUMBER]. The door was closed, and when she opened it, she saw Resident 1 on the floor, lying on the base of the Hoyer lift. LS 4 immediately assessed the resident who was awake, alert, and in pain. LS 4 called Emergency Medical Services (EMS) and Resident 1 was transferred to the hospital. LS 4 stated that CNA 5 was working alone, even though two staff members are required when using the Hoyer lift. LS 4 stated the sling was in poor condition and all the straps were frayed, likely from repeated laundering. LS 4 stated she believed staff were aware of the sling condition but did not report it to management. LS 4 stated she conducted an in-service on 5/10/26 for the staff assessing and using Hoyer slings with the Hoyer lift. A review of the facility's policy and procedure titled, Total Mechanical Lift, dated 5/4/23, indicated, .3. Staff must check the sling, bindings and loops for fraying, wear and tear, and damage. 6. Place the sling under resident: a. Two staff required. These findings represent past noncompliance with this regulatory requirement. Observation of the newly purchased slings in new condition was conducted, and staff interview confirmed direct care staff in-services had been conducted with regards to the use of the 2-person assist lift/transfer device. Staff competency verification and in-service attendance was also documented. There was sufficient evidence that the facility corrected the violation as of 5/22/26, and no other occurrences of noncompliance were identified. At the time of the survey, the facility was in substantial compliance with this regulatory requirement, and therefore, this violation does not require a plan of correction.		