

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

Printed: 10/09/2026
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 07/08/2026
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure the electronic submission of the Payroll Based Journal (PBJ, a system by which skilled nursing facilities submit staffing information to the Centers for Medicare and Medicaid [CMS]) data as required quarterly when the Certification and Survey Provider Enhanced Reporting system (CASPER, an assortment of real-time reports that allows SNFs the opportunity to pinpoint areas where changes in care and operations are necessary to improve performance) report indicated there was no information for the fourth quarter (Q4-10/25 through 12/25). This failure prevented regulatory agencies, residents, and residents' families from being able to verify that facilities had enough staff to provide necessary care to residents. A review of CMS' PBJ Staffing Data Report indicated, No Data Submitted for Quarter. During an interview on 7/9/26 at 1:51 p.m., the Administrator (ADM) confirmed quarterly PBJ data must be submitted to CMS and stated the corporate office was responsible for submitting the PBJ data. In a further interview at 4:54 p.m., the ADM stated the corporate office made an error and acknowledged the PBJ data was not submitted for the 1st quarter of 2026.		

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the nursing staff failed to ensure appropriate treatment for an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) for one resident (Resident 1) of three sampled residents when Resident 1's indwelling urinary catheter bag was found on the floor. This failure placed Resident 1 at risk to develop an infection. A review of Resident 1's face sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of Retention of Urine (inability to fully or partially empty the bladder). A review of Resident 1's physician orders dated 6/15/26 indicated, Foley Catheter Care to be provided every shift. During an observation in Resident 1's room on 7/8/26 at 8:46 a.m., Resident 1's indwelling catheter bag (collection bag) was observed to be lying on its side directly on the floor beneath his bed. During a concurrent observation and interview in Resident 1's room on 7/8/26 at 11: 23 a.m., Certified Nursing Assistant 1 (CNA 1) confirmed the collection bag was directly on the floor and stated a collection bag on the floor could cause an infection in the resident's bladder. CNA 1 did not attempt to move the collection bag from the floor. During a concurrent observation and interview in Resident 1's room on 7/8/26, at 11:41 a.m., Licensed Nurse 1 (LN 1) confirmed the collection bag seen directly on the floor and stated due to Resident 1's bed being in the lowest position the collection bag had nowhere to hang on the bed frame. LN 1 stated the collection bag should not be on the floor for cleanliness, the floor is so dirty. LN 1 moved the collection bag from a side lying position to an upright one on the floor. During a concurrent observation and interview on 7/8/26 at 12:45 p.m., the Director of Nursing Services (DON) confirmed the collection bag was directly on the floor and stated, It is in a privacy bag at least. The DON directed CNA 1 and another staff member to raise the bed enough to appropriately hang the collection bag, so it did not touch or rest on the floor. During an interview on 7/8/26 at 2:20 p.m., the Infection Preventionist (IP) was shown the picture taken depicting Resident 1's collection bag left on the floor. The IP stated, I do not approve of this. The IP further stated leaving a collection bag on the floor could result in bacteria entering the system via the catheter tubing, leading to an infection. The IP stated it did not matter that the collection bag was in a cloth privacy bag; the bacteria could still travel up the catheter tubing and work their way into the urethra (the tube which carries urine from the bladder to the outside of the body). During an interview on 7/8/26 at 3:10 p.m., the Director of Staff Development (DSD) stated nursing staff were taught never to leave urine collection bags on the floor during orientation. The DSD stated ensuring the collection bag was appropriately hanging was a part of the foley care provided each shift. The DSD stated because the floors were so dirty, leaving a collection bag on the floor was an opportunity for an infection to develop. A review of facility policy titled Indwelling Catheter - Insertion, Maintenance and Discontinuation of, revised 7/22/25, indicated, Position the drainage bag below the level of the patient's bladder, but don't place the drainage bag on the floor.		