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 01/29/2026

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide services according to professional standards of practice for three of 21 sampled residents (Resident 4, Resident 14, and Resident 40) when:Medication was not administered to Resident 14 according to the recommended guidelines.72-hour monitoring was not performed for Residents 4 and 40 following a change of condition (COC),A care plan was not initiated for Resident 40 following a COC, and; Neurological (related to the nervous system, which includes the brain, spinal cord, and nerves that control body functions, movement, and sensation) checks were not completed for Resident 4 post-fall. These failures had the potential for:Resident 14 to experience a reduced therapeutic effect from the medication and increased fatigue, muscle aches and low heart rate, Increase Resident 4 and Resident 40's chance of experiencing further complications after a COC,Placing Resident 4 at risk for unmet care needs and inadequate care planning, and;Decreasing the facility's potential to recognize a COC for Resident 4, which could have led to a delay in treatment with other negative outcomes. A review of Resident 14's admission record indicated, Resident 14 was admitted 8/2023 with a diagnosis of hypothyroidism (low activity of the thyroid gland). A review of Resident 14's order summary report dated 1/29/26 indicated Resident 14 had physician's orders for: Famotidine (a medication to reduce stomach acid) oral tablet 20 mg (mg-a unit of measurement). Give one tablet by mouth in the morning for gastroesophageal reflux disease (GERD- stomach acid flows back up into the esophagus and causes heartburn), and; Levothyroxine (a medication to regulate thyroid levels) 88 micrograms (mcg – a unit of measurement) by mouth in the morning for hormone. A review of the medication review regimen (MRR) dated 12/26/25, indicated famotidine can be given without regards to meals. However, it should not be given at the same time as levothyroxine. Please consider changing the administration time of famotidine 20 mg to 9 a.m. A review of Resident 14's 12/21/25 to 1/29/2026 medication administration records (MAR) indicated that famotidine and levothyroxine were both given at 6 a.m. to Resident 14. During a concurrent phone interview and record review on 1/29/26 at 9:12 a.m., the Consultant Pharmacist (CP) confirmed he made the recommendations on the MRR and stated levothyroxine shouldn't be given together with other medications because it could bind with those medications and could decrease effectiveness. (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 01/29/2026
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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 1/29/26 at 10:45 a.m., Licensed Nurse 2 (LN 2) reviewed Resident 14's 12/21/25 to 1/29/2026 MAR and confirmed that both medications have been administered at 6 a.m. LN 2 stated that levothyroxine should not be given with other medications and if he saw that order he would discuss it with the physician or pharmacist for clarification. He further stated that giving levothyroxine with other medications could decrease the effectiveness of the medication. A review of a facilities policy and procedure (P&P) titled, Medication – Administration, dated 8/19/25, indicated, All medications shall be administered by licensed nursing staff according to .current best practice and state and federal regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. 2: A review of Resident 40's admission record indicated he was admitted to the facility in December 2025 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (a brain injury caused by blocked or reduced blood flow to the brain), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 40's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 12/26/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 15, which indicated his cognition was intact (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). During an interview on 1/26/26 at 2:32 p.m., Resident 40 stated he had diarrhea a few days in a row. Resident 40 further stated on 1/24/26 his brief had to be changed at least three times during episodes of diarrhea. Resident 40 stated he had not been eating much because of the diarrhea and upset stomach. A review of Resident 40's SBAR (Situation, Background, Assessment and Recommendation- a communication technique used in healthcare to facilitate clear and concise information following a change of condition) Communication form dated 1/23/26 at 9:30 p.m. indicated, [Resident 40] reported five episodes of diarrhea, green mucus like with no foul odor. A review of Resident 40's progress notes, type, System Note, dated 1/23/26 from 9:30 p.m. thru 1/26/26 11:34 p.m., indicated Resident 40 was only monitored on 1/25/26 at 11:50 p.m., and 1/26/26 at 11:34 p.m. following his COC related to diarrhea. A review of Resident 4's admission record indicated he was admitted to the facility in January 2026 with medical diagnosis which included fracture of first cervical vertebra (neck bones), fracture of the left pubis (the front part of each side of the hip bone), and multiple rib fractures. A review of Resident 4's MDS dated [DATE], indicated his BIMS score was 13, which indicated his cognition was moderately impaired. A review of Resident 4's progress notes titled, eINTERACT SBAR Summary for Providers, dated 1/14/26 at 6 a.m. and 1/17/26 at 1:16 p.m., indicated he had an unwitnessed fall on both occasions. A review of Resident 4's progress notes, type, System Note, dated 1/14/26 6 a.m. thru 1/20/26 11:20 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., indicated Resident 4 was monitored only on 1/14/26 at 1:51 p.m., 1/14/26 at 11:35 p.m., 1/16/26 at 3:49 a.m., 1/18/26 at 11:35 p.m., 1/19/26 at 11:50 p.m., and 1/20/26 at 11:20 p.m., following his COCs related to falls. 3. A review of Resident 40's undated care plan report, indicated no evidence that a care plan was initiated following his COC related to diarrhea. During an interview on 1/28/26 at 3:56 p.m., the Treatment Nurse (TXN) stated that after a COC was initiated in a resident's electronic medical record, it triggered 72-hour monitoring every shift. When asked if a change to the resident's care plan was required following a COC, the TXN stated, Definitely, every COC requires a care plan to be initiated and or updated. The TXN stated it was important to monitor Resident 40 because he was at risk for developing dehydration due to having diarrhea. The TXN further stated it was important that the issues Resident 40 was experiencing not be exacerbated (to make a problem worse).The TXN stated care plans guided staff on how to care for residents, what to expect, and what to monitor. The TXN further stated, Care plans paint a picture of what is going on with the patient and what is needed so that the necessary care can be provided. During a concurrent interview and record review on 1/29/26 at 10:36 a.m., the DON was asked if a COC was required to be care planned. The DON responded, Absolutely, so that there is a plan of care in place so we know how to treat the COC. The DON stated it was her expectation that 72-hour monitoring was performed every shift for a resident following a COC. The DON confirmed nursing staff worked 12 hr. shifts, so she would expect two progress notes per day from nursing staff regarding COC monitoring. The DON stated monitoring was important, To see if there are any changes- if the resident's condition is worsening or better. To see if the care plan is working, or communicating any monitored change with the doctor. The DON confirmed Resident 40's care plan was not initiated or revised following his COC dated 1/23/26. The DON confirmed that no 72-hr monitoring was completed on either day shift or night shift on 1/24/26, day shift on 1/25/26, and day shift on 1/26/26. Subsequently, the DON reviewed Resident 4's record and provided evidence that 72-hr monitoring was completed day shift on 1/15/26, and 1/19/26. The DON confirmed that no 72-hr monitoring was completed for Resident 4 night shift on 1/15/26, or on day shift 1/16/26. The DON confirmed Resident 4 fell again on 1/17/26 at 1:16 p.m. The DON further confirmed that no 72-hr monitoring was completed on day shift on 1/18/26 or on 1/19/26 for this last fall. A review of the facility's P&P titled, Change in Condition, dated 8/2022, indicated, The Licensed Nurse will.Update the care plan to reflect the resident's current status.Document each shift for at least seventy-two (72) hours when there is a change in the resident's condition. A review of the facility's document titled, LVN STAFF NURSE JOB DESCRIPTION, no date, indicated, Completes all required documentation including resident observations, interventions, and patient response(s) in the medical record in accordance with policy.Assists in developing, reviewing, revising, and updating resident plans of care as indicated. 4. A review of Resident 4's neurological check lists indicated post fall neuro-checks were completed on 1/14/26 at 7:55 p.m. and 11:55 p.m., and on 1/15/26 at 3:55 a.m. and 1:12 p.m., due to his fall on 1/14/26 at 6 a.m. (above) A review of Resident 4's Skilled Nursing Facility (SNF) Hospital Transfer Form indicated he (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred to the hospital post fall on 1/14/26 at 6 a.m. A review of Resident 4's progress note type, Alert Note, dated 1/14/26 at 9:37 a.m., indicated Resident 4 had returned from the hospital. During a concurrent interview and record review on 1/29/26 at 10:36 a.m., the DON stated her expectations following a fall was the following, If it's an unwitnessed fall- always do neuro-checks. The DON further stated neuro-checks were ongoing for 72-hrs after a fall. The DON confirmed she expected nursing staff to follow the timing flow chart on the neurological flow sheet. The DON stated neuro-checks were important because, If there is some sort of neurological change the MD (Medical Doctor) needs to be notified immediately. Subsequently, the DON reviewed Resident 4's neurological check lists and confirmed the assessments were not completed to her expectation. The DON further stated she would expect the neuro-checks to begin immediately post-fall and when the resident returned from the hospital for 72-hours. A review of the facility's document titled, Neurological Flow Sheet, revised 7/2016, indicated, Vital Signs and Neuro Checks.every (q) 15 min (minutes) x (for) one hour.q 30 min x one hour.q one hour x four hours.q four hours x 24 hour/total (72) hours. A review of the facility's P&P titled, Fall Management Program, dated 2022, indicated, Neurological Assessment.For an unwitnessed fall.the licensed nurse will complete 72 hours following the fall incident.Perform neurological checks at the ordered frequency or as listed below equaling 72 hours.every 15 minutes x 1 hour, then every 30 minutes x two hours, then every one hour x four hours, then every four hours x 65 hours OR until the physician states it is no longer necessary OR after 72 hours if the resident's condition is stable.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure completed annual performance reviews, commonly known as competency/skills checks, for two of five sampled Certified Nursing Assistants (CNAs, unlicensed healthcare staff providing direct, hands-on nursing or nursing-related services to the residents of the facility) (CNA 4 and CNA 6). Additionally, the facility did not ensure abuse and dementia training was provided for two CNAs in this same sample (CNA 3 and CNA 7). Cross reference F947. This failure placed facility's residents at risk for receiving substandard quality of care, which could have resulted in harm. During a concurrent interview and record review on 1/28/26 at 2:02 p.m. with the Director of Staff Development (DSD), CNA 4's employee training file was reviewed. The DSD acknowledged CNA 4's last annual skill/competency assessment was completed on 9/16/24, which was four months overdue for a required annual skill/competency assessment.During a concurrent interview and record review on 1/28/26 at 2 p.m. with the DSD, CNA 6's employee training file was reviewed. There was a skills/competency checklist that had no employee signatures or dates on it. The DSD could not confirm that CNA 6 completed this or any other annual skills/competency assessment.During a concurrent interview and record review on 1/28/26 at 2:06 p.m. with the DSD, CNA 3's and CNA 7's training files were reviewed. The DSD acknowledged there was missing evidence of abuse and/or dementia training for each of these CNAs, indicating these employees might not be able to respond properly to abuse situations, or have the knowledge to effectively communicate and care for certain residents in the facility. The DSD stated it was known that there were training issues that needed to be addressed at the facility, and that this area was being currently addressed by the quality improvement committee.A review of the facility policy and procedure titled, Staff Competency Evaluation, effective 6/04/24, indicated, staff are required to have competency validation based on their job description or assigned duties .re-education will be provided to the employee who is unable to satisfactorily perform the skill, followed by a re-evaluation of the competency.During a review of [Name of facility] Facility Assessment, reviewed on 1/26/26, indicated under training requirements, Staff training/education and competencies - yearly review of select clinical competency and as needed for competency .include dementia management training and abuse prevention training.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act upon the Consultant Pharmacist's (CP) recommendations in a timely manner for Residents 1, 3, 6, 14, 16, 17, 18, 19, 24, 57, 76, 83, and 85, out of a census of 87 residents. This failure had the potential to result in medication-related problems or errors, such as prolonged use, excessive doses or unmonitored usage, due to the irregularities identified and reported by the CP.1.A review of Resident 1's admission record indicated Resident 1 was admitted on 9/2025 with a diagnosis of Benign Prostatic Hyperplasia (BPH- enlarged prostate).A review of Resident 1's order summary report dated 1/29/26 indicated Resident 1 had a physician's order for tamsulosin HCI (medication to treat an enlarged prostate gland) oral capsule 0.4 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). The order indicated, Give one capsule by mouth, one time a day for BPH.A review of the Pharmacist Recommendation to Prescriber medication regimen review (MRR) for 12/01/25 to 12/31/25, indicated a recommendation to administer tamsulosin 0.4 mg 30 minutes after the same mealtime each day. The MMR indicated, Capsules should be swallowed whole; do not crush, chew, or open.2. A review of Resident 3's admission record indicated Resident 3 was admitted on 9/2025 with a diagnosis of hereditary spastic paraplegia (a group of rare and progressive inherited disorders that cause weakness and stiffness of the legs).A review of Resident 3's order summary report dated 1/29/26 indicated Resident 3 had a physician's order for docusate sodium (medication for constipation)100 mg. The order indicated, Give two capsules by mouth two times a day for constipation.A review of the MRR indicated to update the orders to include, Hold for loose stool.3. A review of Resident 6's admission record indicated Resident 6 was admitted on 7/2021 with a diagnosis of BPH.A review of Resident 6's order summary report dated 1/29/26 indicated Resident 6 had a physician's order for finasteride oral tablet five mg. The order indicated, Give one tablet by mouth one time a day for BPH.A review of the MRR indicated that this medication was classified as a hazardous medication and could not be manipulated, crushed or opened during administration without appropriate personal protective equipment (PPE). The MMR indicated, Please use appropriate precautions for receiving, handling, storage, preparation, administration and disposal .Please add to order: Hazardous Drug - Please use appropriate PPE.4. A review of Resident 14's admission record indicated Resident 14 was admitted on 8/2023 with a diagnosis of hypothyroidism (low activity of the thyroid gland). A review of Resident 14's order summary report dated 1/29/26 indicated Resident 14 had a physician's order for famotidine (a medication to reduce stomach acid) oral tablet 20 mg. The order indicated, Give 1 tablet by mouth in the morning for gastroesophageal reflux disease (GERD- stomach acid flows back up into the esophagus and causes heartburn) and levothyroxine (a medication to regulate thyroid levels) 88 micrograms (mcg - a unit of measurement) by mouth in the morning for hormone.A review of the MRR indicated famotidine could be given without regards to meals however, it should not be given at the same time as levothyroxine. The MMR indicated, Please consider changing the administration time of famotidine 20 mg to 9 a.m.5. A review of Resident 16's admission record indicated Resident 16 was admitted on 3/2025 with a diagnosis of hypertension (HTN - high blood pressure).A review of Resident 16's order summary report dated 1/29/26 indicated Resident 16 had a physician's order for lisinopril (a medication to lower blood pressure) oral tablet 20 mg. The order indicated, Give 20 mg by mouth at bedtime for HTN.A review of the MRR indicated to consider the addition of monitoring parameters to high blood pressure orders. The MMR indicated, Please consider adding - Hold if: HR (heart rate) less than 60 bpm (beats per minute) or SBP (systolic blood pressure) less than 100 mmHg (millimeters of mercury, a unit of measurement), to these orders.6. A review of Resident 17's (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission record indicated Resident 17 was admitted on 12/2025 with a diagnosis of constipation.A review of Resident 17's order summary report dated 1/29/26 indicated Resident 17 had a physician's orders for senna (medication to treat constipation) oral tablet 8.6 mg. The order indicated, Give two tablets by mouth one time a day for constipation and acetaminophen (a medication for pain) 325 mg oral tablet. Give two tablets by mouth every 24 hours as needed for pain at bedtime.A review of the MRR indicated to update the senna order to include, Hold for loose stool and to update acetaminophen order to include, do not exceed three grams of acetaminophen in 24 hours from all sources.7. A review of Resident 18's admission record indicated Resident 18 was admitted on 7/2024 with a diagnosis of gout (form of severe arthritis in the joints).A review of Resident 18's order summary report dated 1/29/26 indicated Resident 18 had a physician's order for allopurinol (medication to treat gout) oral tablet 300 mg. The order indicated, Give one tablet by mouth one time a day for gout.A review of the MRR indicated to consider changing allopurinol order to include, give with food/meals .Add to the directions to ensure compliance.8. A review of Resident 19's admission record indicated Resident 19 was admitted on 10/2023 with a diagnosis of metabolic encephalopathy (a general term for any disease, damage, or malfunction of the brain that alters its structure or function).A review of Resident 19's order summary report dated 1/29/26 indicated Resident 19 had a physician's orders for docusate sodium100 mg. The order indicated, Give one capsule by mouth one time a day for constipation, polyethylene glycol (medication for constipation)17 gm/scoop. Give one scoop by mouth one time a day for constipation, and senna oral tablet 8.6 mg. Give one tablet by mouth two times a day for constipation.A review of the MRR indicated to update the orders to include, Hold for loose stool and add to the polyethylene glycol order, Stir in four to eight ounces juice or other liquids.9. A review of Resident 24's admission record indicated Resident 24 was admitted on 8/2024 with a diagnosis of Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks).A review of Resident 24's order summary report dated 1/29/26 indicated Resident 24 had a physician's orders for finasteride oral tablet five mg. The order indicated, Give one tablet by mouth one time a day for BPH.A review of the MRR indicated that this medication was classified as a hazardous medication and could not be manipulated, crushed or opened during administration without appropriate personal protective equipment (PPE). The MMR indicated to consider adding to the order, Hazardous Drug - Please use appropriate PPE.10. A review of Resident 57's admission record indicated Resident 57 was admitted on 1/2021 with a diagnosis type 2 diabetes (a chronic condition where the body doesn't produce enough insulin and the glucose level in the blood is high).A review of Resident 57's order summary report dated 1/29/26 indicated Resident 57 had a physician's orders for melatonin (supplement for regulating sleep cycles) three mg. The order indicated, Give three mg by mouth at bedtime for supplement.A review of the MRR indicated to update the orders to consider changing the indication of use to, for Circadian Rhythm Regulation (the body's natural 24-hour clock for sleepiness at night and alertness during the day).11. A review of Resident 76's admission record indicated Resident 76 was admitted on 11/2023 with a diagnosis of type 2 diabetes with diabetic polyneuropathy (a common, progressive complication of diabetes caused by chronic high blood sugar damaging peripheral nerves).A review of Resident 76's order summary report dated 1/29/26 indicated Resident 76 had a physician's order for docusate sodium 100 mg. The order indicated, Give one by mouth two times a day for constipation.A review of the MRR indicated to update the orders to include, Hold for loose stool.12. A review of Resident 83's admission record indicated Resident 83 was admitted on 7/2003 with a diagnosis of constipation.A review of Resident 83's order summary report dated 1/29/26 indicated Resident 83 had a physician's order for senna oral tablet 8.6 mg. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The order indicated, Give one tablet by mouth two times a day for constipation.A review of the MRR indicated to update the orders to include, Hold for loose stool.13. A review of Resident 85's admission record indicated Resident 85 was admitted 3/2025 with a diagnosis of acute pancreatitis (inflammation of the pancreas).A review of Resident 85's order summary report dated 1/29/26 indicated Resident 85 had a physician's order for docusate sodium 100 mg. The order indicated, Give two capsules by mouth two times a day for constipation.A review of the MRR indicated to update the orders to include, Hold for loose stool.During an interview and record review on 1/29/26 at 8:30 a.m., the Director of Nursing (DON) confirmed none of the MRR recommendations dated 12/26/25 were implemented and had been given to the physician. The DON stated the CP recommendations should be followed because they prevented potential medication errors from happening.During an interview and record review on 1/29/26 at 9:12 a.m., the CP confirmed he performed a MRR on 12/26/25. The CP stated his expectations were that the recommendations were reviewed within two weeks of being submitted, and if not they should be escalated by the DON to be implemented.During an interview and record review on 1/29/26 at 9:30 a.m., the Administrator (ADM) stated 11/21/25 was the last MRR review which was signed by the physician. The ADM stated her expectation was that the 12/26/25 CP recommendations should have been followed and implemented in a timely manner.A review of the facility's policy and procedure (P&P) titled, Medication Regimen Review, reviewed in 2024, indicated, All findings and recommendations are reported to the director of nursing and the attending physician, the medical director and the Administrator .Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's [active record] and reported to the Director of Nursing, Medical Director and prescriber as appropriate.A review of the facility's P&P titled, Documentation and communication of consultant pharmacist recommendations, reviewed in 2024, indicated, The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion .Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review .Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her [within 30 days], the Director of Nursing and/or the consultant pharmacist may contact the Medical Director.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored safety and within accepted professional standards of practice for a census of 87 residents when:Loose pills were found in a medication cart,Medications were found without open dates, and;Used insulin pens were found comingled in the same drawer.These findings had the potential to result in medication errors, decreased medication therapy, and harm to the residents of the facility. During a concurrent interview and C wing medication cart inspection on 1/28/26 at 1:14 p.m., with the Director of Nursing (DON), the DON confirmed the following: 10 loose pills were found in the medication cart. The DON stated loose pills could potentially be given mistakenly to residents or be taken by staff.Six medications were found without open dates. The DON stated open dates were necessary to ensure that medications were not outdated. The DON further stated that if these medications were administered to residents, they could potentially cause adverse effects or be less therapeutic.Six used insulin pens belonging to different residents were found comingled in the same drawer. The DON stated the insulin pens should be prevented from touching each other because that could cause cross contamination.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, reviewed in 2024, the P&P indicated, Medications are stored safely and properly .Medication storage areas are kept clean and free of clutter .When the original seal of a manufacturer's container is initially broken. the nurse shall place a date opened sticker on the medication and enter the date opened.

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to comply with federal regulations related to the oversight of food service operations when the facility did not have a dedicated Registered Dietitian (RD, food and nutrition experts with a minimum of a graduate degree from an accredited dietetics program, who completed a supervised practice requirement, and passed a national exam) for a census of 87 residents.This failure had the potential to compromise dietary services rendered to the facility's residents.During the recertification survey conducted from 1/26/26 through 1/29/26, multiple dietary issues were identified including recipes not being followed (Cross Reference F803), dumpster lid not being closed (Cross Reference F814), and issues pertaining to kitchen sanitation, cleanliness, maintenance, equipment, and food storage (Cross Reference F812).During an interview on 1/26/26 at 10:20 a.m., the Dietary Supervisor (DS) stated one Registered Dietitian (RD 1) worked remotely (off site) and attended weekly meetings by video call or email to discuss resident weight changes and diets. The DS confirmed RD 1 did not physically come to the facility to assess residents' nutritional status or to provide consultation with him about the kitchen operation.During an interview on 1/28/26 at 1:08 p.m., the DS stated the last time the facility hired an onsite RD was over a year ago. The DS stated in 2025, the facility had a travel RD (an RD contracted through another agency) that worked full-time in the facility from January to June. The DS further stated that a Regional Registered Dietitian (RRD, a Registered Dietitian that oversees the company's nutrition programs, companywide menu planning and regulatory compliance across multiple locations) came to the facility infrequently, with the last visit earlier in 2025.During an interview and record review on 1/28/26 at 2:43 p.m., the Regional Consultant (RC) confirmed RD 1 reviewed resident weights virtually with the Director of Nursing (DON) weekly. The RC confirmed RD 1 did not visit the facility for assessments. The RC stated the last full-time RD (RD 2) was hired from 3/11/25 to 6/7/25 through a staffing agency. The RC confirmed the last onsite visit by RRD was on 3/20/25. The RC stated it was required that an RD be physically present at the facility once a week.During an interview on 1/29/26 at 11:16 a.m., the RRD stated she visited the facility periodically to support the kitchen, address dietitian questions, and ensure systems were in place. The RRD confirmed having no set visitation schedule and managed 30 facilities. The RRD mentioned her visits varied, sometimes occurring every few months and other times every six months.A review of the facility's undated document titled, [name of facility] Kitchen Training for IDDSI, indicated a kitchen training was conducted on 11/30/25, in which only the DS and 1 cook were present. The document further indicated RD 3 focused on the updated systems, reviewed menu planning, and ensured compliance with IDDSI dietary requirements.A review of the facility's job listing indicated that the Registered Dietitian was responsible for the following duties, Will oversee the nutritional clinical operations and survey kitchen and dining programs for a facility.Provide Medical Nutrition Therapy and work with the Dietary Supervisor to ensure that quality food, service and nutritional care are being provided to residents by performing the following duties.Evaluates the Medical Nutrition Therapy needs of the residents and implements appropriate interventions to improve their nutritional status.Coordinates resident care with the Interdisciplinary Team.Coordinates with the Nutrition Services Supervisor/Manager the review and customization of the regular and therapeutic menus.Conducts meal rounds and interviews staff and residents to ensure residents are receiving foods in the amount, type, consistency, and frequency required to maintain or improve nutritional status.Routinely inspects the food service area(s) and practices for compliance with company policies, procedures, standards, and applicable federal, state, and local regulations.Participates in the long-term (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care survey process.Provides in-service training to Nursing Center staff on topics related to Nutrition and Foodservice.A review of the facility's document titled, Regional Dietitian Job Description, revised on 6/14/16, indicated the Regional Dietitian was responsible for the following duties, Visits facilities on a regular basis to ensure systems are in place and to monitor sustainability to ensure appropriate care is provided to all residents.Establish rapport (relationship) with residents.Make rounds and identify Food Safety and Sanitation, Clinical Nutritional practice, Environmental and regulatory violations.Provide education.Assure that the dietary department functions as a member of the health care team.Assure that residents with nutritional problems are identified and monitored by the facility Registered Dietitian.Assure that food served is safe, nutritious, and palatable.Assist the dietary department in oversight of the sanitation reviews and dining programs.Assure continuing quality in food and nutrition services.Ensure the dietary department continues to function within departmental and facility policies and complies with State and Federal regulations.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to prepare meals using methods that conserved nutritive value, flavor, and appearance when the recipes were not followed for a facility census of 87 residents. This failure had the potential for leading to malnutrition, weight loss, impaired wound healing, and increased susceptibility to disease. During an observation in the kitchen on 1/27/26 at 9:35 a.m., [NAME] 2 (CK 2) was observed preparing food for the lunch menu, which included herb crusted beef roast, mashed potatoes with gravy, zesty spinach, and garlic bread. No recipes were present at the cook's station.During a concurrent observation and interview on 1/27/26 at 11:15 a.m. in the kitchen, CK 2 was seen adding an unmeasured amount of butter to a mixture of butter, garlic, and parsley using a spatula, without using any measuring tools. CK 2 stated she estimated it was about one fourth cup of butter for the garlic toast. Subsequently, CK 2 was observed combining four tablespoons of garlic powder with one pound of melted butter in a container. According to CK 2, this mixture, which did not include red pepper flakes or salt, was going to be used in the zesty spinach recipe intended to serve 72 residents. Next, CK 2 poured an unmeasured amount of milk into a container of dry breadcrumbs, stating there was no specific recipe for pureed garlic bread. The Dietary Supervisor (DS), who was also present, confirmed the existence of such a recipe. CK 2 continued without using it, pouring another unmeasured amount of milk and claiming it was half a cup. CK 2 stated both containers of breadcrumbs with milk were meant to make 13 servings. No measuring tools were observed being used.During a concurrent observation and interview on 1/27/26 at 11:30 a.m. in the kitchen during meal preparation, CK 2 took boiled spinach from the stovetop and attempted to drain it using a strainer in a sink. CK 2 accidentally spilled some of the spinach into the sink, leaving portions in the pot, strainer, and sink. The DS then intervened and strained the remaining spinach for the zesty spinach recipe. Subsequently, CK 2 was observed adding the unmeasured powdered garlic and butter mixture to the remaining spinach. When asked how much garlic butter mixture was added to the spinach, CK 2 replied, Seriously, I don't know! Then, CK 2 and the DS stated they did not add salt to anything. The DS further stated, Yeah, we don't use salt.During an interview on 1/28/26 at 1:08 p.m., the DS stated that the recipe must be visible to the cook while preparing food and must be used and followed. The DS stated he could not confirm if CK 2 had or followed recipes during the lunch preparation on 1/27/26. The DS stated he did not approve of cooking staff, eyeballing it, when preparing food. The DS explained that eyeballing it meant adding ingredients by sight rather than using measuring tools. The DS stated his expectation was that cooking staff use measuring tools when preparing food. The DS further stated, It's important that measuring tools are used so that the right amount of ingredients are used in the recipe. The DS confirmed that not using measuring tools affected the taste, appearance, and nutrition of the food. The DS could not confirm if measuring tools were used during 1/27/26 lunch meal preparation. The DS further stated, I was just trying to save the spinach after it spilt.During an interview on 1/28/26 at 2:07 p.m., CK 2 stated that she did not always follow the recipes. CK 2 further stated, It depends what it is. I don't like the recipe book sitting on the table because it gets in the way. CK further stated, It is typically not ok to eyeball food measurements. It is supposed to be precise because that's the measurements you are following.During an interview on 1/29/26 at 11:16 a.m., the Regional Registered Dietitian (RRD, Registered Dietitian who oversees the company's nutrition programs, companywide menu planning and regulatory compliance across multiple locations) stated recipes should be followed and utilized. The RRD further stated her expectation was that measuring tools be used during food preparation. The RRD stated spices could be an exception, and (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated, If salt is in the recipe, it should be included and measured. The RRD verified salt should not be with-held if the recipe called for it. The RRD further stated measuring ingredients during meal preparation was important To make sure the nutrient content is equivalent to the menu calculations and analysis. A review of the facility's document titled, RECIPE: ZESTY SPINACH, dated 2025, indicated, Serve 72 [residents].Spinach, frozen 20 lb 4 oz (ounce- a unit of weight).Margarine 1 1/? cups.Garlic powder 1 1/2 to 3 tbsp.Salt 2 1/4 tsp (teaspoon- a unit of measure).Red pepper flakes 1 to 1 1/2 tbsp.Saute margarine, garlic, salt and red pepper flakes together for 1-2 minutes.A review of the facility's document titled, RECIPE: PUREED (IDDSI LEVEL #4) BREADS, CAKES, COOKIES, PANCAKES, FRENCH TOAST, SWEET ROLLS, WAFFLES, TORTILLAS, SANDWICHES, And Other BREAD PRODUCTS, dated 2025, indicated, Serves 12 [residents].Warm milk or cold milk if product is to be served cold.1 1/2 to 3 cups.Puree on low speed adding milk gradually.A review of the facility's policy and procedure titled, Standardized Recipes, revised on 7/01/14, indicated, Food products prepared and served by the dietary department will utilize standardized recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to provide food storage and preparation, sanitary conditions, as well as maintain kitchen equipment and the kitchen environment in accordance with professional standards for food service safety for a census of 87 residents when:1. Kitchen staff did not protect food from physical contaminants (e.g. hair nets and beard nets were not worn, and cook was wearing jewelry), 2. Kitchen environment was not maintained (e.g. kitchen walls had areas of missing paint),3. Sanitary conditions of the kitchen floor and kitchen wares was unkept (three-drawer storage bin used to store cooking utensils with black scuffs and sticky residue on the outside, and with crumb particles on the inside, textured kitchen floors with blackened debris, garbage remnants, food crumbs, and paint chips along the bottom of the walls and around stationary equipment, and one utility cart used for food and beverage delivery with debris and dust particles on shelf surfaces),4. Approximately four scoops used for food preparation and tray-line were stored wet, 5. Small wares were not discarded when damaged (e.g. tip of the can opener had missing metal, and four cutting boards discolored and with deep cut groves), and6. Emergency water was expired.These findings had the potential to cause food borne illness and infections to the residents consuming facility-prepared meals. 1.During a concurrent observation and interview in the kitchen, on 1/26/26 at 8:15 a.m. with the Dietary Supervisor (DS), three kitchen staff (DA 1, DA 2, and CK 1) were observed without hair nets. The DS confirmed this observation.During a kitchen observation on 1/26/26 at 12:34 p.m., CK 3 was observed with facial hair and without a beard net.During an interview on 1/26/26 at 2:30 p.m., the DS confirmed CK 3 should have worn a beard net as his facial hair was longer than 1 inch. The DS stated the beard net was necessary, To keep the hair out of the food.During a kitchen observation on 1/27/26 at 9:35 a.m., CK 2 was observed wearing a hoop earring in each ear, and a watch while preparing meals.During an interview on 1/28/26 at 1:08 p.m., the DS stated that kitchen staff should always wear hair nets and avoid jewelry or watches while preparing food to minimize contamination risks. The DS further stated, Especially a watch, it's near the hand area.During an interview on 1/28/26 at 2:26 p.m., the Infection Preventionist (IP) stated she expected all kitchen staff to wear hair nets and beard nets while in the kitchen. The IP further stated, So, hair doesn't fall into the food. The IP stated watches and dangly earrings should not be worn by kitchen staff. The IP further stated something could break off the dangly earring and go into the food. The IP stated, Jewelry, you can't be sure it can be cleaned properly. It could harbor bacteria.A review of the facility's policy and procedure (P&P) titled, Dietary Department-Infection Control, revised on 2/29/24, indicated, Cover hair, beard, and mustache with an effective hair restraint.while in any kitchen and food storage area.watches are not permitted to be worn while working in the food service area or while preparing food.To ensure that the dietary department is maintained in a sanity condition in order to prevent food contamination and the growth of disease producing organisms and toxins.A review of the facility's undated document titled, Dietary Services Supervisor/Certified Dietary Manager- Job Description, indicated, Maintains a safe and sanitary working environment in compliance with Federal and State of California Guidelines.A review of the facility's undated document titled, Cook-Job Description, indicated, Performs duties in a safe and sanitary manner.A review of the facility's undated document titled, Dietary Assistant/Dishwasher-Job Description, indicated, Maintains a safe and sanitary work environment.2. During an initial kitchen observation on 1/26/26 at 8:15 a.m., the wall to the left of the stovetop and oven in the main cooking area was observed with rough-textured scratches and patches of missing paint. The wall was observed to have three different tones of wall paint: white, beige, and yellow toned beige. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	largest scratch of paint was above an electrical outlet and measured approximately 7 inches (in.) in length and 5 in. wide and exposed white paint under a beige wall. Scattered areas of peeled or scratched paint were observed to the left of the same electrical outlet in variable sizes. One measured approximately 1 in. in length and 3 in. in width and exposed white paint under a beige wall. Another mark located just above the previous one measured approximately 7 in. in length and 1 in. wide and exposed white paint under a beige wall. Further up on the wall and to the left a 2 in. by 2 in. patch of missing paint exposed a yellow toned beige paint under a beige wall. Above, and directly under a light switch, another patch of missing paint exposed white paint under a beige wall and measured approximately 2 in. by 2 in. Paint chips were observed on the floor directly under the scratches and patches of missing paint on the wall.During an interview on 1/29/26 at 7:30 a.m., the DS confirmed the paint was scratched and chipped around the stovetop and oven in the main cooking area. The DS further stated, It [the wall] should be repainted because the paint chips could fall and possibly get in the food.A review of the Food and Drug Administration's 2022 Food Code, section 4-202.16, titled, Nonfood-Contact Surfaces, indicated, NonFOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. It further stated that, Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms.3. During a concurrent observation and interview with the DS in the kitchen on 1/26/26 at 8:15 a.m., a three-drawer storage bin used to store measuring cups, spoodles (a cross between a serving spoon and a ladle [a long-handled spoon with a cup-shaped bowl]), spatulas, and scoops was observed with gray to dark brown and black smears and scuffs that covered the exterior. All three drawer handles were sticky to the touch. The drawer holding the spatulas and spoodles contained a dry, crumbly substance in shades of light beige, beige, and black. The DS confirmed the entire three-drawer storage bin was, dirty, on the outside and inside. The DS further stated, Yea, we probably need a new one.it's dirty. It looks like food crumbs.During an observation on 1/26/26 at 8:15 a.m., within the initial kitchen tour, the floor below the handwashing sink and around a surrounding food preparation table against the wall was observed with black residue and grime (dirt ingrained on the surface of something), dark brown and dark beige colored particles of an unknown substance, a paper clip, and a dime. Concentrated areas of black residue and grime surround the area where the legs of the table touched the floor. Observed under another food preparation table across the room was black residue and grime where the floor met the wall, a paper clip, a rubber band, and a bread closure tab. Behind the table, brown, dried fluid was observed dripping down the wall. Wall paint chips were observed on the floor to the left of the stovetop and oven.During an interview on 1/26/26 at 10:30 a.m., the DS confirmed the floor under the handwashing sink, the surrounding food preparation table, under the food preparation table across the room, and the wall behind that table was unkept. The DS stated, Yea, the floor is dirty and it looks like crumbs. It's a slip resistant floor and hard to clean. The DS confirmed the paint chips on the floor to the left of the stovetop and oven. The DS stated, The floors need to be deep cleaned.During a concurrent observation and interview on 1/26/26 at 11 a.m. with the DS present, a three-tiered utility cart was observed in a corner of the dining room with two empty pink beverage pitchers, and approximately one eighth (1/8) full pitcher with clear liquid stored on the second shelf. The cart was observed with crumbs, dried, orange-colored crusted particles, and large dust particles on all three shelves. The DS stated the utility carts in the dining room were used for the delivery of drinks and pitchers of water to the residents. The DS confirmed the utility cart was, dirty, and stated the dirty carts should not be used for food and beverage services. The DS stated the utility (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cart should be cleaned after each use. The DS further stated he did not know who was responsible for cleaning the utility carts used for food service.During an observation on 1/26/26 at 12:27 p.m. in the dining room during meal service, the same utility cart was observed uncleaned.During an interview on 1/28/26 at 1:08 p.m., the DS stated kitchen cleaning was completed daily. The DS confirmed a log was available for kitchen staff to document the cleaning tasks once completed. The DS stated it was his responsibility to review the cleaning log to ensure the cleaning tasks were completed. The DS was unable to provide a cleaning log. The DS stated, I don't know what happened to it [the cleaning log].During an interview in the dining room on 1/29/26 at 7:40 a.m., the Director of Staff Development (DSD) stated the utility carts in the dining room were used for beverage and food service to residents. The DSD further stated some of the utility carts were used to collect dirty dishes. The DSD stated the utility carts were returned to the corner of the dining room after each use and it was expected that kitchen staff would clean the utility carts after each meal service.A review of the facility's P&P titled, Cleaning Schedule Operational Manual-Dietary Services, revised on 10/1/14, indicated, The dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the Dietary Manager (DM).The DM will develop a cleaning schedule that included the frequency of which equipment ad areas are to be cleaned.cleaning schedule is posted weekly.includes tasks assigned to specific positions within the dietary department.The DM monitors the cleaning schedule to ensure compliance.A review of Food and Drug Administration's 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, indicated, The objective to cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.4. During a concurrent observation and interview in the kitchen on 1/26/26 at 8:15 a.m., with the DS present, approximately four scoops used for food preparation and tray line were observed stored wet in the three-drawer storage bin. The DS confirmed the scoops were stored wet. The DS stated the scoops should not have been stored wet because it [a wet environment] could increase the growth of bacteria.A review of Food and Drug Administration's 2022 Food Code, section 4-901.11, titled Equipment and Utensils, Air-Drying Required, indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items.prevents them from drying and may allow an environment where microorganisms (living organisms such as bacteria, fungi, and viruses) can begin to grow.5. During the initial kitchen observation on 1/26/26 at 8:15 a.m., a can opener stationed on a food preparation table was observed with white label remnants on the pointed blade tip. The pointed blade had visible signs of metal peeling and was worn.During an interview on 1/26/26 at 10:45 a.m., the DS stated the can opener should be cleaned daily. The DS stated, Yea, it's dirty and needs to be cleaned. The DS further stated the can opener blade needed to be changed because metal could come off and go into the food.During a concurrent observation and interview in the kitchen, on 1/26/26 at 10:50 a.m., with the DS present, a light brown, green, light blue, and red cutting boards were observed with black discolored surfaces and stored in the cutting board rack. Deep blade markings could be felt digitally on all four boards. The DS confirmed these observations, and stated, Cutting boards with deep groves are hard to clean and can harbor bacteria. The DS confirmed all four cutting boards should not be used.A review of Food and Drug Administration's 2022 Food Code, section 4-202.15, titled, Can Openers, indicated that Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized.A review of Food and Drug Administration's 2022 Food Code, section 4-501.11, titled, Good (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Repair and Proper Adjustment, indicated, The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury.A review of Food and Drug Administration's 2022 Food Code, section 4-501.12, titled, Cutting Surfaces, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.6. During a concurrent observation and interview on 1/28/26 at 1:08 p.m. with the Maintenance Director (MAIN D), and the DS, the facility's emergency water was stored with an expiration date of 12/15/25. The DS and MAIN D confirmed the emergency water was expired and needed to be replaced.A review of the facility's P&P titled, Disaster Planning Operational Manual-Dietary Services, revised 11/1/14, indicted, The disaster food supply shall be.Rotated a minimum of every six months to assure continued quality food items.A review of the facility's P&P titled, Food Storage and Handling, revised on 2/29/24, indicated, Dry storage area.rotate stock.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage was properly contained for a census of 87 residents when one out of two dumpsters were observed with open lids, was overflowing with trash, and the area around it was littered with garbage.This failure had the potential to expose the facility environment to odors, insects, pests, and disease, which could have caused harm to the residents. During a concurrent observation and interview on 1/26/26 at 10:40 a.m. with the Dietary Supervisor (DS), one of the two facility dumpsters was left open with plastic bags filled with garbage piled above the top of the dumpster. The dumpster was observed without the lids on to provide closure to the dumpster. One bag of garbage and a box was on the ground next to the dumpster. The DS confirmed the dumpster was overflowing and was too full to close the lids. The DS confirmed there was garbage in the surrounding area outside of the dumpster. The DS further stated, The lids are supposed to be closed to keep the pests and critters out.During an interview on 1/29/26 at 9:58 a.m. with the Maintenance Director (MAIN D), he stated, They are supposed to be able to close the lids- birds can get into it [the dumpster], and because of infection control reasons. The MAIN D further stated, The lids are to remain closed the whole time.A review of the facility's policy and procedure titled, Medical Waste-Containers & Storage-Infection Control Manual, revised on 1/1/12, indicated, Medical waste containers are located throughout the facility and are kept covered at all times.Medical waste containers used by the facility are.closable.Medical waste is stored so that it is protected from animals and does not provide a breeding place or a food source for insects and rodents.

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 01/29/2026
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a safe and functional environment for one of 21 sampled residents (Resident 70) when Resident 70's light was not in working condition. This failure had the potential to increase Resident 70's risk for accidents, feelings of frustration and lack of independence. A review of Resident 70's admission record indicated she was admitted to the facility in July, 2025, with medical diagnosis which included spinal stenosis (a narrowing of the spinal canal which puts pressure on the spinal cord and nerves), strabismus (eyes are misaligned and do not point in the same direction) and vascular dementia (when damaged blood vessels reduce blood flow and oxygen to the brain, impairing thinking, memory, and function).A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 1/07/26, indicated Resident 70 had moderate cognitive (relating to or involving the processes of thinking and reasoning) impairment, and required partial to moderate assistance (helper does less than half the effort) to lie down from a sitting position, sit to stand, transfers in and out of bed, and ambulation.During a concurrent observation and interview on 1/27/26 at 8:30 a.m., Resident 70 stated there was no pull cord on her light behind the head of her bed. The pull cord was observed to be approximately 3 inches (in.) long. Resident 70 stated she could not reach the pull cord and even if she could, the switch on the wall by the door would need to be turned on first. Resident 70 stated this was frustrating because she required assistance to walk and used a wheelchair. Resident 70 explained that if the light switch was not on and the cord was pulled, nothing would happen (the light would not turn on). Observations confirmed that even when the switch was turned on, the light did not function. Resident 70 stated she had no control over turning her light on or off. Resident 70 expressed she found it particularly frustrating when the sun set, saying, I have to get used to no continuous light. Resident 70 stated she consistently had to ask someone else to operate the light for her. Resident 70 further stated that she would like her light to work more than anything. Resident 70 stated maintenance was aware and had not returned to fix the light.During an interview on 1/27/26 at 8:45 a.m., Certified Nurse Assistant 9 (CNA 9) confirmed that Resident 70 could not reach the light switch. CNA 9 verified the pull cord on the light switch was approximately 3 in. in length. CNA 9 confirmed when cord was pulled, the light did not turn on.During a concurrent observation and interview on 1/29/26 at 9:58 a.m., the Maintenance Director (MAIN D) stated it was never brought to his attention that Resident 70's light was not in working condition. After observing Resident 70's light, MAIN D confirmed it was only partially working. MAIN D confirmed that Resident 70 could not reach the pull cord.During an interview on 1/29/26 at 2:15 p.m., the Business Office Manager (BOM) stated MAIN D was aware that Resident 70's light required to be repaired. The BOM stated the issue was mentioned on multiple occasions during staff morning meetings and stand-down meetings. The BOM stated the issue had been in discussion for approximately four months. The BOM reported that as of today, Resident 70's light and pull cord had still not been fixed. The BOM further stated, The resident [Resident 70] is really trying to make this her home.During an interview on 1/29/26 at 2:20 p.m., the Regional Consultant (RC) confirmed MAIN D was aware that Resident 70's light required repair. The RC stated it was important that Resident 70 had access to her light, to promote quality of life. The RC stated this issue affected Resident 70's independence. The RC further stated, It's a hazard for her [Resident 70] to not be able to see. It is not a home-like environment. The RC stated MAIN D had been failing to perform maintenance repairs and following up on the overall condition of the building.A review of the facility's policy and procedure (P&P) titled, Resident Safety, revised 4/2021, indicated, To provide a safe and hazard free environment.A review of the facility's P&P titled, Resident (continued on next page)

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	01/29/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rights- Personal Property, revised in January of 2012, indicated, To ensure a quality of life of all residents by allowing residents to create a home-like environment.A review of an undated facility document titled, DIRECTOR OF ENVIRONMENTAL SERVICES JOB DESCRIPTION, indicated, Ensures a safe, comfortable, sanitary environment for residents.in accordance with Federal, State and Corporate requirements.Orders and maintains supplies and equipment necessary to meet center needs.