STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056300	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granada Rehabilitation & Wellness Center, LP	2885 Harris Street Eureka, CA 95503

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on interview and record review, the facility failed to develop and implement a fall risk care plan to meet the medical, nursing, mental, and psychosocial needs for one (Resident 1) of three sampled residents. This deficient practice resulted in Resident 1 experiencing injury and pain secondary to an unwitnessed fall on 4/26/25. Findings: A review of Resident 1's, Admission Record, dated 5/7/25, showed Resident 1 was initially admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis (hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness) affecting the right side, morbid obesity (a complex chronic disease in which you have a body mass index [BMI] of 40 or higher, with normal range for adults considered to be between 18.5 and 24.9), muscle weakness, dementia (a general term for a group of symptoms that affect thinking, memory, and other cognitive [relating to, being, or involving conscious intellectual activity-such as thinking, reasoning, or remembering] abilities. It's not a single disease, but rather a collection of conditions that can damage brain cells, leading to a decline in mental function), dysarthria (a motor speech disorder caused by weakness or lack of control of the muscles involved in speech production), long term use of anticoagulants (medications that stop blood from clotting too easily), and a history of falling. A review of Resident 1 ' s, Minimum Data Set Section C (MDS-a standardized assessment tool used in long-term care facilities to evaluate residents' health status, functional capabilities, and other relevant information), dated 4/7/25, indicated Resident 1 had a BIMS (Brief Interview for Mental Status - used to identify delirium [a serious change in mental abilities, resulting in confused thinking and a lack of awareness of someone's surroundings] and needed supports in patients living in skilled nursing facilities and long-term care facilities) score of 9, indicating Resident 1 had moderate cognitive impairment (MCI-cognitive deficits that significantly impact daily life. Individuals with moderate MCI experience difficulties with memory, language, judgment, and problem-solving, often requiring assistance with household tasks and finances. They may become confused about where they are or what is happening and struggle with both routine and complex tasks). (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 0656 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s, MDS - GG, dated 4/7/25, indicated Resident 1 was partially dependent (not completely reliant on others for basic needs like bathing, dressing, or eating, but may need help with some day-to-day activities) on facility staff for self-care, indoor mobility (the ability to move or to be moved. It can describe a person's capacity to walk, move around, or change body position) and functional cognition (how an individual utilizes and integrates his or her thinking and processing skills to accomplish everyday activities in clinical and community living environments), and experienced one-sided impairment of the upper and lower limbs. Resident 1 was reported to be wheelchair dependent. A review of Resident 1 ' s, After Visit Summary, dated 3/31/25, indicated Resident 1 was transferred to the facility after a 13-day acute hospitalization due to pre-syncope (the sensation of feeling like you are about to faint, but without actually losing consciousness), and a fall at home. A review of Resident 1 ' s, Fall Risk Evaluation , dated 3/31/25, indicated due to past fall history, incontinence (involuntary leakage of urine or stool), diseases, recent hospitalization and multiple medications, Resident 1 was a high fall risk. A review of Resident 1 ' s, SBAR (Situation, Background, Assessment, Recommendation- a structured communication framework used in healthcare, particularly nursing, to facilitate clear and concise information sharing about a patient's condition or situation) Communication Form and Progress Note, dated 4/26/25, indicated Resident 1 was heard yelling for help, and was found on the floor of his bedroom. Resident 1 displayed new onset pain evidenced by moaning, groaning and facial grimacing, and was sent out to acute care hospital via 911 ambulance. A review of Resident 1 ' s, After Visit Summary, dated 4/26/25, indicated Resident 1 visited the acute hospital emergency room (AH ER) after falling and was diagnosed with a closed (where the skin is not broken) rib fracture of the left side. A review of fax correspondence from Granada Rehabilitation and Wellness Center to CDPH (California Department of Public Health), dated 4/28/25, reported Resident 1 complained of unrelieved pain one day after returning from AH ER, after administration of ordered lidocaine patch (a medication patch applied to the skin that numbs a specific area of the body, blocking pain signals going to the brain) and Tylenol (generic name acetaminophen- effective for mild to moderate pain, such as headaches, muscle aches, backaches, and toothaches). The facility reported this to Resident 1 ' s physician, who ordered Resident 1 receive a stronger pain medication (Toradol-generic name ketorolac, which treats short-term moderate to severe pain. It works by decreasing swelling) for five days. During a concurrent observation and interview on 5/8/25 at 9:58 a.m., with Resident 1 in his bedroom, Resident 1 was lying in bed on his right side, stating he was in severe pain, while groaning and grimacing. Resident 1 was pointing and grabbing at his left side. Licensed Vocational Nurse 1 (LVN 1) was alerted of Resident 1 ' s condition. LVN 1 responded by assessing and administering ordered pain medication to Resident 1. During a concurrent observation and interview on 5/8/25 at 11:26 a.m. with Resident 1, Resident 1 was still in bed, laying quietly with his CPAP ([continuous positive airway pressure] machine that treats sleep apnea [a potentially serious sleep disorder in which breathing repeatedly stops and starts]. It keeps airways open during sleep and delivers oxygen through a mask). Resident 1 stated he was more comfortable now, and he was trying to rest before lunch, and did not want to talk. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/8/25 at 12:15 p.m., with LVN 1, LVN 1 stated fall risk care plans were usually initiated by nursing management when a resident was first admitted . LVN 1 stated any licensed nurse should initiate a care plan for a new condition, or if a care plan was otherwise needed. LVN 1 stated a nursing care plan was necessary to guide nurses in possible interventions and precautions for actual and potential problems. During an interview on 5/8/25 at 1:40 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 1 ' s physician had ordered Tramadol (a centrally acting analgesic [pain medication that reduces pain signals to the brain] used to treat moderate to moderately severe pain in adults) to better manage Resident 1 ' s ongoing pain. During a concurrent interview and record review on 5/8/25 at 2:40 p.m., with the Director of Nursing (DON), the DON stated the facility did not initiate a fall risk nursing care plan for Resident 1 prior to his unwitnessed fall on 4/26/25. Review of nursing care plans showed a fall risk care plan for this resident was not developed until 4/28/25. The DON stated this should not have happened, and a nursing care plan was a roadmap, of care interventions for the care and safety of residents of the facility. During a review of facility P & P titled, Fall Management Program, dated 3/13/21, the P & P indicated, As part of the admission assessment, the licensed nurse will complete a fall risk evaluation. If a fall risk factor is identified, document interventions on the Resident ' s care plan .the Interdisciplinary Treatment Team (involves healthcare professionals from various disciplines working together to provide complete care for residents. These teams aim to improve outcomes through collaboration, open communication, and shared decision-making) will initiate, review and update the Resident ' s fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall as needed.