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	08/06/2025

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility nursing staff failed to follow professional standards when one licensed nurse gave a dose of one of four sampled residents, Resident 1's, prescription medications to a staff member who was experiencing symptoms of anxiety. This failure resulted in the potential misuse of Resident 1's medication when the nurse, who was entrusted with full access to the medication cart, gave the medication to someone to whom it was not prescribed, and resulted in the loss of a dose of Resident 1's medication when the dose was thrown away.During an observation on 8/6/25 at 9:45 a.m., two medication carts were parked next to the nurses' station. Two security cameras were noted mounted on the ceiling pointed at the nurses' station.During an interview on 8/6/25 at 11:29 a.m., Licensed Staff B stated nurses were not allowed to give medications to staff from the medication cart because the medications belonged to the residents, staff did not have a doctor's order for the medications, and the nurses did not know whether the staff members might have any side effects to the medications.During a phone interview on 8/6/25 at 1:44 p.m., Unlicensed Staff A verified a nurse gave her a medication from the medication cart for anxiety. Unlicensed Staff A stated the nurse was Licensed Staff B. Unlicensed Staff A stated she told Licensed Staff B that she was having anxiety and Licensed Staff B told her, I can give you something for that and Licensed Staff B reached into the medication cart and pulled out a medication. Unlicensed Staff A stated she took the medication from Licensed Staff B and threw it away in the hopper (a sink with a flushing mechanism designed for safe and hygienic disposal of clinical waste like the contents of bedpans) because she did not know what it was going to do to her.During an interview on 8/6/25 at 2 p.m. with Administrator and Assistant Director of Nursing (ADON), Administrator stated that she was sitting in her office watching the security cameras when she saw Licensed Staff B hand Unlicensed Staff A a pill cup at the Station 1 cart. Administrator stated she told ADON what she saw and asked ADON to go investigate. ADON stated she approached Licensed Staff B and Unlicensed Staff A at the medication cart and asked them to explain what was happening. ADON stated Licensed Staff B told her Unlicensed Staff A was not feeling good, so she gave her a dose of propranolol (a prescription medication for high blood pressure, chest pain, and irregular heart beat). ADON stated Licensed Staff B pulled a bubble pack of propranolol out of the medication cart to show ADON what she had given to Unlicensed Staff A. ADON stated she told Licensed Staff B that at no time should she give medications to staff off the cart. Administrator stated Licensed Staff B was written up (disciplinary action) for giving the medication to Unlicensed Staff A.During an interview on 8/6/25 at 2:25 p.m., Licensed Staff B verified she gave propranolol from the medication cart to a staff member who was having anxiety. During an observation and concurrent interview on 8/6/25 at 2:40 p.m., ADON opened the drawer to one of the medication carts at Station 1 and pulled out a bubble pack of propranolol 40 mg (milligrams) tablets labeled for Resident 1. ADON stated the tablet of propranolol that Licensed Staff B gave to Unlicensed Staff A belonged to Resident 1.Review of Resident 1's facesheet indicated an admission date of 11/11/19. Review of Resident 1's physician orders revealed an order dated 11/12/24 for propranolol 40 mg one tablet by mouth three times a day for hypertension (high blood pressure). Review of facility job description LVN (licensed vocational nurse) Staff Nurse, not dated, indicated, Prepares/administers medications as ordered by the physician and within the legal scope of practice.Review of facility policy and procedure Medication - Administration, last revised 1/1/2012, indicated, Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner.