

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2026
NAME OF PROVIDER OR SUPPLIER  Granada Rehabilitation & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure a baseline care plan (BCP, a document created within 48 hours of a resident's admission to a nursing home, outlining the initial care needed to ensure residents' safety and well-being, focusing on basic needs and resident-specific information) was completed timely, for two out of two sampled residents (Resident 1 and Resident 2), when neither BCPs were completed within 48 hours of admission and Resident 1's BCP did not address her Pressure Ulcers (PUs, a localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for nearly one month after admission. These failures had the potential to result in newly admitted residents receiving unsafe care and put Resident 1 at an increased risk for further skin breakdown and worsening of PUs. Findings: A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 1/7/2026 with a diagnosis of Dementia (a progressive state of decline in mental abilities) and stage 2 PU (partial-thickness loss of skin, presenting as a shallow open sore on the tailbone) on both sides of their buttocks. A review of Resident 1's BCP indicated Resident 1 was admitted to the facility with stage 2 PU on 1/7/26 but the BCP was not completed until 2/5/26. A review of Resident 2's face sheet indicated an admission date of 2/2/2026 with a diagnosis of Dementia and muscle weakness. A review of Resident 2's BCP indicated Resident 2 was admitted to the facility on [DATE] but the BCP was not completed until 2/5/26. During a concurrent interview and record review on 2/5/26 at 11:17 a.m. with the Director of Nursing (DON), Resident 1's and Resident 2's BCPs, both completed on 2/5/26, were reviewed. The DON stated the facility's policy was to ensure the BCP was completed within 48 hours of admission. The DON confirmed the BCP was important to provide an overview of short term safe and appropriate care and not completing a BCP within 48 hours of admission increased the risk of unsafe care for the newly admitted resident. The DON confirmed neither Resident 1 or Resident 2's BCPs were completed within 48 hours of admission. The DON also confirmed the facility had submitted a Plan of Correction (POC, document submitted by facility detailing how they will fix deficiencies found during an inspection) that indicated the facility would ensure that specifically skin care plans would be developed and implemented within 24 hours of a resident's admission. The DON explained, a skin care plan was to provide guidance for care to prevent skin injury and/or to promote wound healing. The DON stated if there was no skin care plan, the resident could be at risk for skin breakdown and/or wound worsening. The DON confirmed Resident 1's skin care plan/care plan for the PU was not initiated until 2/5/26. A review of the facility's policy and procedure (P&amp;P) titled Person-Centered Care Planning, revised 4/24/25, it indicated .the baseline care plan will be developed and implemented, using the necessary combination of prob specific care plans to promote continuity of care and communication among facility staff, increase resident's safety, and safeguard against adverse events, within 48 [hours] of resident's admission.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 056300	If continuation sheet Page 1 of 3

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure professional standards of quality were provided, for one out of two sampled residents (Resident 3), when: 1. Resident 3 administered a nebulizer (a machine that turns liquid medication into a fine mist that is inhaled into the lungs through a mouthpiece or mask) treatment herself without physician order or assessment for self-medication administration, 2. LN B inaccurately documented in Resident 3's Electronic Medication Administration Record (EMAR, a digital system used to track and document the administration of medications, ensuring accuracy and timeliness in medication delivery) polyethylene glycol (a laxative/stool softener use to treat occasional constipation [stool that is hard, dry, or difficult and painful to pass]) had been given. These failures could lead to Resident 3 receiving incorrect dosing of medication, worsening of condition and lead to incorrect treatment decisions. Findings: A review of Resident 3's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 11/2025 with a diagnosis Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing). A review of Resident 3's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 11/20/25, with a score of 12 indicating Resident 3 had moderate cognitive impairment (some memory issues, confusion). A review of Resident 3's EMAR dated 2/5/26 indicated Resident 3 received a 9:00 a.m. dose of: Ipratropium-Albuterol (medications to treat COPD) inhalation solution for shortness of breath (difficult breathing) and wheezing (a high-pitched sound made when breathing is restricted in the lungs), and polyethylene glycol for constipation. During an interview on 2/5/26 at 9:39 a.m., Resident 3 stated for her 9 a.m. medication administration, she was in her room without staff present and giving herself a nebulizer treatment as she always had done. Resident 3 added, but today she did not finish the nebulizer treatment because when the nurse returned and turned off the nebulizer machine, Resident 3 saw there was still medication left in the nebulizer cup (part of nebulizer machine that holds the liquid medication). Resident 3 also stated she had not received her laxative yet, which would have been mixed with water in a disposable cup. Resident 3 stated she felt the nurse today was in a rush which made Resident 3 feel anxious (a state of worry, nervousness, or unease). During a concurrent observation and interview on 2/5/26 at 9:46 a.m., with Licensed Nurse (LN) B and Resident 3, in Resident 3's room. LN B verified Resident 3 had administered the nebulizer treatment to herself and acknowledged Resident 3 did not have an order to self-administer the nebulizer treatment. LN B explained a physician's order and a self-medication administration assessment, to ensure resident safety, was necessary to be completed before a resident was to self-administer a medication. LN B verified the nebulizer cup removed from Resident 3 still had greater than 1 ml of medication left in it. Resident 3 stated she had not received her polyethylene glycol/laxative yet either. LN B told Resident 3 the polyethylene glycol had been administered this morning. Resident 3 pointed to the trash can on the right side of her bed and said look there, if you really gave it to me, show me the cup where you had mixed the med. LN B checked and verified there was no cup in the trash can and then stated she remembered that she had not given Resident 3 the laxative after all. During a concurrent interview and record review on 2/5/26 at 9:59 a.m., with LN B, Resident 3's EMAR for 2/5/25 was reviewed. LN B verified Resident 3's EMAR dated 2/5/25 showed polyethylene glycol was documented as administered to Resident 3. LN B acknowledged she had not followed the facility policy when she documented giving Resident 3 the polyethylene glycol when she had not actually given it to Resident 3. During a concurrent interview and record review on 2/5/26 at 11:17 a.m., with the Director of Nursing (DON), Resident 3's POS for 2/2025 was reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON verified Resident 3 did not have an order to self-administer medications. The DON also verified there was no self-administer medication assessment completed for Resident 3. The DON stated to ensure resident safety, it was the facility's policy that a self-medication administration assessment needed to be completed, and a physician order be obtained prior to allowing residents to self-administer medications. The DON stated it was the facility's policy to document the administration of a medication on the EMAR after it was administered to the resident. The DON stated if a nurse had documented a medication was administered when it was not, it could lead to loss of trust, misleading clinical decisions and could put residents' safety at risk. A review of the facility's policy and procedure (P&amp;P) titled NP80 Medication-Self Administration, revised 7/31/25, the P&amp;P indicated .the LN completes the self-administration of medication assessment which evaluates the resident. a physician's written order is required before a resident begins self-administration. A review of the facility's policy and procedure (P&amp;P) titled NP76 Medication-Administration, revised 6/26/25, the P&amp;P indicated .Right Documentation: immediately document after administration.</p>