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	02/11/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, Licensed Nurses (LNs) and Certified Nursing Assistants (CNAs) failed to provide urinary catheter care for one resident (Resident 1) out of three sampled residents when Resident 1 developed a facility acquired mucosal membrane skin injury (damage to the skin and/or underlying soft tissue caused by pressure from a medical device used for therapeutic purposes) and urinary tract infection (UTI- an infection of the bladder/urinary tract) from an indwelling urinary catheter (flexible tube remaining in the bladder to continuously drain urine into an external bag).This failure resulted in Resident 1 sustaining a laceration which measured 1.3 centimeters (cm-a unit of measure) long and 0.5 cm wide to Resident 1's urinary meatus (the external opening of the penis) and a severe infection with Pseudomonas Aeruginosa (a serious, often antibiotic-resistant bacteria that causes UTI).Findings:A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (a common, noncancerous enlargement of the prostate gland in men which causes difficulty urinating) and diabetes mellitus (a chronic disorder which results in the body's inability to use food energy efficiently and causes wounds to heal slowly). A review of Resident 1's care plan, dated 12/18/25, indicated Resident 1 had an indwelling urinary catheter due to his diagnosis of BPH with lower urinary tract symptoms. Resident 1's goal was to be free from catheter related trauma. Staff were expected to Monitor/ document [Resident 1] for pain/discomfort due to [the urinary catheter and].Monitor/record/report to MD [physician] for s/sx [signs and symptoms] [of a] UTI: pain, burning.A review of Resident 1's order recap report indicated Resident 1 had the following orders in place:-Starting on 1/4/26, staff were expected to insert an indwelling urinary catheter inserted for urinary retention (inability to drain the bladder); and,-Starting on 1/4/26, staff were expected to provide urinary catheter care to Resident 1.A review of Resident 1's Medication Administration Record (MAR), dated January 2026, indicated LNs conducted urinary catheter care for Resident 1 during the day, evening, and night shifts from 1/13/26 through 1/19/26.A review of Resident 1's skin check assessment dated [DATE] at 10:30 a.m. indicated Resident 1 did not have any skin concerns on his genitals.A review of Resident 1's shower sheets, dated 1/14/26 through 1/18/26 indicated CNAs did not find any skin changes on Resident 1 and LNs reviewed and verified what was documented on the shower sheets.A review of Resident 1's Occupational Therapist (OT) progress note dated 1/19/26 indicated, Therapist noted drainage from catheter site and requested wound nurse to assess the area for possible infection. Therapist assisted the wound nurse initially with initiation of pericare, however a second nurse assisted with a more complete assessment of [Resident 1's] needs .[Resident 1] was agreeable to OT session however [Resident 1] required assessment by nursing for possible infection at catheter site.Toileting hygiene= Dependent.Shower/bathe self= Not applicable.Lower body dressing [i.e. putting on underwear or putting on pants]= (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dependent.Personal hygiene= Dependent.A review of Resident 1's progress note dated 1/19/26 at 12:01 p.m., indicated, .Treatment RN [Registered Nurse] was notified by [Occupational] therapy of a possible ureteral infection.[Resident 1's] urethra [the tube connecting the bladder to the outside of the body allowing for excretion of urine] is split down the middle, approx. [approximately] 1/ 2 - inch thickness, with purulent [containing pus (a thick, milky, white-yellow to brown fluid that accumulates at the site of infection] green and yellow exudate [discharge] inside the urethra, and climbing down the [urinary] catheter tube. [Resident 1] states 'this thing needs to come out. It hurts. It's been like this for a while.'A review of Resident 1's progress note dated 1/19/26 at 12:11 p.m. indicated, Resident has pain in the area when moving or providing catheter care.A review of Resident 1's skin check assessment dated [DATE] at 12:18 p.m., indicated Resident 1 had a new facility acquired skin issue which involved a laceration located on Resident 1's urethra on his penis. The assessment described the wound as having erythema (redness of the skin or mucosal membrane) and edema (swelling) with increased exudate. The wound measured 1.5 cm in length and 0.5 cm wide, and Resident 1 described the pain as sharp. A review of Resident 1's progress note dated 1/19/26 at 1:44 p.m. indicated, MD [physician] ordered UA [urinalysis- a common diagnostic test that analyzes urine to detect infections] & C&S [culture and sensitivity- a test used to identify the specific bacteria causing an infection].to be sent out today.A review of Resident 1's UA and C&S test results dated 1/22/26 indicated the bacteria known as pseudomonas aeruginosa was causing Resident 1's urine to: appear turbid (significantly cloudy); test 3+ positive for white blood cell esterase (an enzyme released by WBC as it fights off bacteria. 3+ indicates the highest amount the test can detect); test positive for blood; test positive for nitrites (a specific marker for UTI); and many bacteria which were all considered to be abnormal.A review of Resident 1's hospital emergency department (ED) note dated 1/23/26 indicated, .Physical Exam.GU [genitourinary- anatomy of the genitals and urinary system] Indwelling [urinary] catheter in place.chronic pressure wounds present. Pus around meatus. Enlarged testicles with swelling, erythema, and tenderness to palpation [touch].positive for large UTI.Final diagnoses [in ED].Urinary tract infection associated with indwelling urethral catheter.During an interview in the facility hallway on 2/11/26 at 1:31 p.m., the Treatment Nurse (TN) stated both the LNs and CNAs were responsible for providing catheter care for residents. The TN stated catheter care was a part of nurses' daily routine of perineal (small area of the body between the anus and the external genitalia) care. The LNs were responsible for following up with the physician for anything concerning.During an interview at the Side 1 nurses' station on 2/11/26 at 1:44 p.m., LN 1 stated CNA staff were responsible for providing catheter care to residents every two hours or sooner if needed. LN 1 further stated CNAs were supposed to report any concerns or if something is not looking right to the LN staff for follow up. LN 1 also stated catheter care was documented in the resident's electronic medical record (EMR).During an interview in the facility conference room on 2/11/26 at 2:14 p.m., the OT stated she was working on transferring Resident 1 from the bed to his wheelchair. The OT stated she pulled up his pants when he yelled, Ow, that hurts! The OT thought she pulled on Resident 1's catheter tubing, which she observed was not secured to his thigh. The OT stated when she looked at his catheter, she found a large smear of yellowish drainage on his pants as well as the tip of his penis. The OT stated the opening on the penis appeared split and she was surprised no one caught this before me. The OT stated she immediately reported her finding to Resident 1's primary nurse.During an interview in the Director of Nursing (DON) office on 2/11/26 at 3:20 p.m., the DON stated the CNA staff were responsible for catheter care, which included cleaning around the meatus. The DON stated CNAs had catheter care listed on the competency checklist which was completed upon hire and assessed annually. The (continued on next page)

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