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	06/24/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one of six sampled residents (Resident 2) from abuse when Resident 2 was struck by Resident 3 during an physical altercation on 6/06/26.This failure resulted in Resident 2 being struck on the right temple and suffering a lingering headache.A review of Resident 2's Face Sheet (a facility demographic), dated 6/10/26, indicated he was admitted to the facility on [DATE], with diagnoses including dementia (a decline in memory, reasoning, and cognitive skills severe enough to interfere with daily life), depression (a serious mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in activities), anxiety, and unsteadiness on feet.A review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/16/26, indicated he had mild cognitive impairment (involves noticeable declines in memory, language, or thinking skills, but are not severe enough to disrupt daily life).A review of Resident 3's Face Sheet, dated 6/10/26, indicated he was admitted to the facility 9/8/25 with diagnoses of congestive heart failure (occurs when the heart muscle becomes too stiff or weak to pump blood efficiently), malnutrition (a serious condition resulting from deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients) and muscle weakness.A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had mild problems with memory, orientation, and decision-making.A review of Resident 3's Psychology Progress Note, dated 6/04/26, indicated Resident 3 was diagnosed with adjustment disorder with depressed mood (an emotional or behavioral reaction to a specific, identifiable life stressor that begins within three months of the event), as evidenced by a reported emotional and behavioral response to medical conditions, functional limitations, increased need for assistance, and rehab placement. This response appears to be causing marked distress that is out of proportion to the severity and intensity of the stressor and is causing significant impairment in social functioning.A review of Resident 3's nursing Progress Notes, dated 6/06/26 at 9:31 p.m., indicated Resident 3's roommate (Resident 2) was watching a war movie on the television, which upset Resident 3. After a verbal exchange, Resident 3 hit Resident 2 on the head several times. Staff responded and separated the residents. A review of Resident 2's nursing Progress Notes, dated 6/07/26 at 1:16 p.m. indicated Resident 2 was immediately assessed following the physical altercation on 6/06/26, and although there was no visible bruising or bleeding, Resident 2 had an elevated blood pressure reading of 159/101 (normal blood pressure reading is 120/80 or less) and complained of headache which lasted until the next day. Resident 2 was given pain medication for discomfort.During an interview on 6/24/26 with the Administrator (ADM) and the Assistant Director of Nursing (ADON), the ADM expressed surprise that this incident would result in a deficiency, but acknowledged that the assault against Resident 2 actually occurred.A review of facility Policy and Procedure (P & P) titled, Abuse Prevention and Management, dated 5/30/24, indicated Prevention.the facility identifies, corrects and intervenes in situations of in which abuse, neglect, exploitation, misappropriation of resident property and/or mistreatment is more likely to occur.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the state mental health authority (Department of Health Care Services [California agency responsible for overseeing the state's required screenings to identify individuals with serious mental illness]) for two (2) of six (6) sampled residents (Resident 3 and Resident 5), who had significant changes in mental health status.This failure had the potential to result in residents not receiving appropriate mental health services based on their most current clinical needs1. A review of Resident 3's Face Sheet (facility demographic) indicated he was admitted to the facility 9/08/25 with diagnosis of congestive heart failure (CHF, occurs when the heart muscle becomes too stiff or weak to pump blood efficiently), malnutrition (when the body does not receive the proper balance of nutrients and calories required to maintain healthy tissues and organ function), and muscle weakness.A review of Resident 3's Notice of PASRR Level 1 (Preadmission Screening and Resident Review, a federally required screening to identify if an individual seeking admission to a Medicaid-certified nursing facility has or may have, a serious mental illness, intellectual disability, or developmental disability) Screening Results, dated 9/01/25, indicated Resident 5 did not require a Level 2 Screening (this evaluation helps determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed) due to Negative for SMI [serious mental illness].A review of Resident 3's Psychology Intake Note, dated 2/17/26, indicated, [Resident 3] reportedly began to experience mood symptoms (i.e., depressed mood, diminished interest, guilt, decreased energy, poor concentration, poor appetite, anhedonia [the inability to experience pleasure or a profound loss of interest in activities you once enjoyed], and insomnia [a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or getting restful sleep]) around the date of admission., and was officially diagnosed with adjustment disorder with depressed mood (an emotional or behavioral reaction to a specific, identifiable life stressor that begins within three months of the event).A review of Resident 3's Psychology Progress Notes, dated 5/17/26, indicated [Resident 3] demonstrated a disorganized thought process today and was very tangential (a communication disorder where a speaker starts on a topic, drifts into unrelated side trails, and never returns to the original point) and repetitive.A review of Resident 3's Nursing Progress Notes, dated 6/06/26 at 9:35 p.m., indicated Resident 3 became upset and agitated when his roommate was watching a war movie in their shared bedroom. Resident 3 then physically attacked his roommate.A review of Resident 3's medical record indicated that the facility did not document notification to the state mental health authority regarding Resident 3's significant change in mental health status.2. A review of Resident 5's Face Sheet, dated 6/24/26, indicated she was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a general term for brain dysfunction caused by chemical imbalances or systemic illnesses in the body, rather than a direct physical injury or structural disease in the brain itself) and cognitive communication deficit (an impairment caused by disrupted brain function, rather than a primary speech or language issue).A review of Resident 5's Notice of PASRR Level 1 Screening Results, dated 6/16/25, indicated Resident 5 did not require a Level 2 Screening due to Negative for SMI.A review of Resident 5's Care Plan Report, initiated 7/17/25, indicated, Focus:.[Resident 5] is having adjustment issues to admission affecting mood. The resident is at risk for altered psychological well-being manifested by little interest/pleasure in doing things.Intervention: Document behavior problems and assess need for behavior management program.A review of Resident 5's Psychology Progress Note, dated 5/19/26, indicated she was diagnosed with adjustment disorder with anxiety (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior).A review of Resident 3's medical record indicated that the facility did not document notification to the state mental health authority regarding Resident 3's significant change in (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental health status.During an interview on 6/24/26 at 2:44 p.m., the Medical Records Director stated she was responsible for ensuring PASRR processes were completed. She stated the MDS Nurse (Minimum Data Set Nurse, evaluates, monitors and documents the clinical needs of long-term care residents) and nursing staff were responsible for notifying her when residents experienced significant mental health changes requiring renewed PASRR referral, but she had not received notification regarding Resident 3 or Resident 5. She stated this process was important to ensure residents are placed appropriately and to protect all residents in the facility.A review of facility Policy and Procedure (P & P) titled, admission Screening Resident Review (PASRR), dated 2022, indicated, Purpose: To ensure that all residents are screened for mental illness and intellectual disability (ID) or a related condition (RC).

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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 - 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 ensure nursing services met professional standards for one (1) of six (6) sampled residents (Resident 2) when complete neurological assessments (subjective and objective data collected through interview and detailed physical examination of the central nervous system [brain, spinal cord] and the peripheral nervous system [other body nerves] was not documented following a head injury.This failure had the potential to delay identification of neurological changes indicative of brain injury or other clinical decline. Cross reference F726).A review of Resident 2's Face Sheet (a facility demographic), dated 6/10/26, indicated he was admitted to the facility on [DATE], with diagnoses including dementia (a decline in memory, reasoning, and cognitive skills severe enough to interfere with daily life), depression (a serious mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in activities), anxiety, and unsteadiness on feet.A review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/16/26, indicated he had mild cognitive impairment (involves noticeable declines in memory, language, or thinking skills, but are not severe enough to disrupt daily life).A review of facility Progress Notes, dated 6/07/26 at 1:16 p.m., indicated Resident 2 had a verbal and physical altercation with his roommate on the previous day and had a lasting headache after being struck on the right temple. The Progress Note further indicated Alert charting was initiated and neuros continued Q4 hrs [every four hours] d/t [due to] complaints of headache. VS [vital signs] and neuros are wnl [within normal limits].During a concurrent interview and record review on 6/24/26 at 3:50 p.m., the Assistant Director of Nursing stated Resident 2's medical chart contained no flowsheets or documentation showing the components of a complete neurological assessment following Resident 2's head injury. The ADON stated documentation such as neuros wnl or neuros at baseline was acceptable and the facility had no neurological assessment policy, procedure, or protocol. When asked how the facility measured competency of performing neurological checks, the DON stated, nurses should know how to do this, and there were no such competencies given by the Director of Staff Development. During an interview on 6/24/26 at 4 p.m. with Licensed Nurse 1 (LN 1), she stated to complete a neurological check she would, check the pupils, check hand grip, take vital signs, look if there is any change in consciousness, and assess for pain.During an interview on 6/24/26 at 4:05 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated that to complete a thorough neurological check she would, take vital signs, assess how [residents] respond and are talking, check pupil size and range of motion of extremities. When asked to explain more about what to look for in the pupils, LN 2 stated look to see if they [residents' pupils] are the dilated or pinpoint.A review of the American Association of Neuroscience Nurses guidance literature titled, Neurological Assessment of the Adult hospitalized Patient, dated 2021, indicated neurological assessments could be challenging for nurses. The report advised, using a standardized approach can help the nurse identify changes that may affect outcomes. A list of assessment components help guide the nurse, creating structure around the identification of neurological changes in the patient. Reflecting those components in the EHR [Electronic Health Record, a secure, digital version of a patient's medical chart] allows the nurse to document findings consistently. A standardized approach can assist with rapid identification of neurological changes so interventions can be initiated promptly.