STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48660 Based on interview and record review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for two residents (Resident 2 and Resident 3) of two sampled residents when the facility reported an allegation of abuse to the California Department of Public Health (the Department) three days after the incident occurred. This failure decreased the facility's potential to ensure resident safety and cause a delayed response by enforcement agencies. Findings: A review of the facility's document titled 5-Day Conclusion Resident to Resident Altercation dated 11/22/24 indicated a Certified Nursing Assistant (CNA) witnessed Resident 3 hitting Resident 2 on the face with a shoe on 11/15/24 at approximately 11:30 p.m. During an interview on 1/7/25 at 2:15 p.m., the Director of Staff Development (DSD) stated it was the facility ' s policy to report an allegation of abuse to the Department within two hours. The DSD confirmed the 11/15/24 allegation of suspected abuse had not been reported to the Department until 11/18/24. During an interview on 1/8/25 at 2:10 p.m., the Administrator stated the expectation was for the abuse coordinator to report any allegations of abuse to the Department within the two-hour time frame. The administrator also stated if the abuse coordinator was unavailable, any member of the management team would be expected to report an allegation of abuse to the Department within two hours. The Administrator confirmed the 11/15/24 allegation of abuse had not been reported to the Department until 11/18/24. A review of the facility ' s policy titled, Abuse Reporting and Investigations, revised March 2018 indicated, The Administrator or designated representative will within two (2) hours notify, by telephone, the Department, the Ombudsman, and Law Enforcement. The policy further indicated a written report will be sent to the Department within two (2) hours.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48660 Based on interview and record review, the facility failed to provide supervision to prevent a fall for one resident (Resident 1) of two sampled residents when Certified Nursing Assistant B (CNA B) left Resident 1 on the toilet unsupervised then left Resident 1 ' s room to attend to another resident. This failure resulted in Resident 1 sustaining a fracture (a complete or partial break of the bone) of the right distal fibula (smaller long bone of the lower leg) and the right distal tibia (larger long bone of the lower leg). Findings: A review of Resident 1 ' s admission record indicated she was admitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness and paralysis of the body) affecting the left dominant side, epilepsy (a nerve disorder in which nerve cell activity in the brain is disturbed, causing seizures [sudden temporary bursts of electrical activity in the brain that can cause changes in body movement, function, or awareness]), and memory deficit following a cerebral infarction (a stroke caused by disrupted blood flow to the brain). A review of Resident 1 ' s clinical record included the following documents: A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/13/24, indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or assistance touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for toilet transfers. The MDS further stated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports limbs, but does half the effort) for toileting hygiene (the ability to maintain perineal [genital and anal area] hygiene, adjust clothes before and after voiding [emptying the bladder] or having a bowel movement). A Fall Risk Care Plan, initiated 8/1/23 indicated Resident 1 was at high risk for falls related to confusion, deconditioning (a decline in the physical functioning of the body), gait (a person ' s manner of walking)/balance problems, urinary urgency and incontinence (inability to control the flow of urine from the bladder), poor communication/comprehension, psychoactive drug use (drugs which affect mental processes), unaware of safety needs, desire to be independent with ongoing overestimation of actual abilities, severe bilateral lower extremity (both right and left legs and feet) neuropathy (weakness, numbness, and pain from nerve damage), history of many falls here, at home, and at previous Skilled Nursing Facility. Fall Risk Assessments, dated 7/30/24, 9/4/24, 9/21/24 and 11/17/24 all indicated Resident 1 was a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1 ' s progress notes between 8/1/24 and 11/30/24 indicated Resident 1 had 4 falls, 3 of which were unwitnessed. An Interdisciplinary Team (IDT, a group of people with different areas of expertise who work together to ensure care) Progress note dated 8/1/24 indicated the Root Cause of Resident 1 ' s fall was, Slipped, and fell to the floor - plus resident has a history of frequent falls. Resident has neuro cognitive deficits [a decline in mental function that is caused by a medical condition] - legs have neuropathy - decreased safety awareness. Resident is very forgetful. Resident has poor judgement. A review of written statement dated 11/17/24 from CNA B about his account of Resident 1 ' s fall indicated, . assisted [Resident 1] by wheelchair to restroom on 11/16/24 around 2235 [11:35 p.m.]. Once [Resident 1] was positioned on the toilet I removed her wheelchair out of restroom to prevent her to attempt to transfer on her own. Before leaving [Resident 1] I reminded her to use call light in restroom when she was finished. While waiting on her I went to assist another resident. On coming back [CNA C] and I heard a resident in room [ROOM NUMBER]B asking for a blanket. While [CNA C] was in room [ROOM NUMBER]B she heard a knock on the wall. On investigating she found [Resident 1] on restroom floor. I proceeded to get charge nurse. A Progress Note, dated 11/17/24 at 00:30 indicated, .this writer called to resident ' s bathroom. Upon arriving, resident was found lying on the floor in the bathroom. Upon assessing resident .there was an obvious ankle injury with severe pain .[Physician] called, informed of situation. Orders received to send to ER [emergency room] for evaluation . A discharge summary from the hospital dated 11/17/24, indicated Resident 1 was diagnosed with a closed fracture of the right ankle. Resident 1 was discharged back to the facility with a splint (a medical device that immobilizes the ankle joint to help with healing)on the right ankle, pain medications, and instructions to follow up with an Orthopedic Physician (a medical professional who diagnoses and treats conditions of the bones, muscles, and joints). During an interview on 1/7/25 at 11:32 a.m., the Director of Nursing (DON) stated she was notified by staff Resident 1 had fallen after she requested privacy while on the toilet. The DON verified Resident 1 had a history of falls. The DON also stated the best practice was for staff to stay within eyesight, so residents did not try to transfer on their own and fall. The DON further stated CNA B could have provided privacy and still stayed in the room. During an interview on 1/7/25 at 1:43 p.m., Licensed Nurse D (LN D) stated Resident 1 required assistance and supervision in the bathroom as she was a fall risk. LN D stated Resident 1 had a history of noncompliance with using the call light. LN D further stated staff should stand by the bathroom door when a resident requested privacy; staff could not have supervised a resident if they left the room. During an interview on 1/7/25 at 2:15 p.m., the Director of Staff Development (DSD) stated best practice when toileting a resident who requests privacy was to be able to see the resident without them seeing you. The DSD further stated staff could not have provided supervision when they were out of the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of a facility policy titled, Fall Management Program, last revised 11/7/2016, the policy indicated, A resident who sustains multiple falls will be considered a high risk to fall and as a result may sustain a major injury.