

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Fortuna Rehabilitation and Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>36790</p> <p>Based on interview and record review, the facility failed to ensure adequate staffing with appropriate competencies was maintained to meet the physical needs of the residents, as evidenced when treatments for wound care were not provided as ordered by the Physician for four of nine sampled Residents: Resident 1, Resident 2, Resident 3 and Resident 4. This failure had the potential for delaying the healing of the wounds and increasing the risk for the wounds to become infected.</p> <p>Findings:</p> <p>During a review of clinical records on 2/20/25, Resident 1's Medical Doctors, Order Summary Report for 2/2025, had the following orders for wound care: 1. Cleanse left breast malignant wound with wound cleanser and pat dry; apply skin barrier cream every day shift for wound care per (wound specialist) instructions. Start date was 8/22/24. 2. Dakins (1/4 strength) External Solution (Sodium Hypochlorite) Apply to coccyx topically every day shift every Mon, Wed, Fri for pressure injury Cleanse with Dakins solution, pat dry, apply calcium alginate to wound bed, cover with mepilex dressing or equivalent. This would be the pressure ulcer (a skin injury caused by prolonged pressure on a bony area of the body) of the coccyx, (the tail bone) cleansed with an antiseptic solution, (Dakins used to prevent infection in wounds,) patted dry, wound bed covered with Calcium alginate, (absorbent wound dressings made from seaweed, alginate) and covered with absorbent foam dressing (Mepilex). Start date was 1/15/25. 3. Sacro-coccygeal: Cleanse with NS (sterile salt water,) or sterile water, pat dry, cover with calcium alginate to fit wound bed, cover with Mepilex or similar dressing, every day shift every Mon, Wed, Fri for Stage 3 Pressure Injury. Start date was 1/3/25.</p> <p>During a review of clinical records on 2/20/25, Resident 1's Treatment Administration Record (TAR) for the month of 2/2025, had the instructions for treatments of Resident 1's wounds and was used to document that the treatments were provided. Resident 1's Breast Malignant (cancerous) Wound treatment was not documented as done for Monday 2/3/25 and Monday 2/10/25. Resident 1's Coccyx pressure ulcer treatment for every Monday, Wednesday and Friday was not documented as done for Monday 2/3/25 and Monday 2/10/25. Resident 1's Sacro-coccygeal (area over the last two bones of the back) pressure ulcer treatment for every Monday, Wednesday and Friday was not documented as done on Monday 2/3/25 and Monday 2/10/25.</p> <p>(continued on next page)</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: 056361
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of clinical records on 2/20/25, Resident 2's Medical Doctors, Order Summary Report for 2/2025 had the following order for wound care. RLE: cleanse with NS, pat dry, apply xeroform, wrap with kerlix every day shift for Stage 3 pressure injury. Start date was 1/22/25. This would be to treat a pressure ulcer on the right below-knee amputation stump by cleansing the wound, apply a petrolatum-based gauze dressing used to keep wounds moist and wrap with a roll of gauze dressing daily.</p> <p>During a review of clinical records on 2/20/25, Resident 2's TAR [CM9] [CD10] for the month of 2/2025, had the instructions for treatments of the pressure ulcer on the right below knee amputation stump. The treatment was not documented as done on 2/3/25, 2/4/25, 2/6/25, 2/7/25, and 2/8/25.</p> <p>During a review of clinical records on 2/20/25, Resident 3's Medical Doctors, Order Summary Report for 2/2025, had the following order for wound care: Vleanse wound on coccyx/upper lesion with NS, pat dry and apply foam dressing every day shift starting 2/19/25.</p> <p>During a review of clinical records on 2/20/25, Resident 3's TAR for the month of 2/2025, had the instructions for treatments of two pressure ulcers. Resident 3's Coccyx pressure ulcer was to be cleansed with saline (NS), patted dry, packed with Dermablue (foam with antiseptic properties), and covered with absorbent foam dressing every three days. Start date was 1/14/25. This was documented as completed on 2/1/25, and not documented as completed for 2/4/25 and 2/7/25. This treatment was documented as completed on 2/10/25 but not done on 2/13/25. Resident 3's upper buttocks pressure ulcer was to be cleansed with saline, patted dry, packed with absorbent dressing and covered with absorbent foam dressing every three days. Start date was 1/31/25. This was not documented as completed on 2/3/25 and 2/6/25. It was documented as done for 2/9/25 and 2/12/25.</p> <p>During a review of clinical records on 2/20/25, Resident 4's Medical Doctors, Order Summary Report for 2/2025, had the following orders for wound care: 1. Lt calf- cleanse with NS, pat dry, calcium alginate with AG (silver) to wound bed, cover with dry, clean dressing. Wrap with kerlix and coban. every day shift for Venous Wound, started on 1/29/25. (Kerlix, long lengths of gauze to wrap wounds, and Coban, a type of bandage that comes in long lengths and secures in place by sticking together). 2. RLE- cleanse with NS, pat dry, cover open areas with xeroform, non-adherent dressing. every day shift for wound care. Start date was 1/29/25.</p> <p>During a review of clinical records, Resident 4's TAR for the month of 2/2025, had the instructions for treatments of two leg wounds, (not considered pressure ulcers.) Resident 4's left calf wound treatment was not documented as provided on 2/2, 2/5, 2/6, and 2/7/25. Resident 4's right leg open wounds treatment was missed on 2/2, 2/5, 2/6, and 2/7/25.</p> <p>During an interview on 2/20/25 at 12:30 p.m., Infection Preventionist (IP) stated the facility had several staff quit at the same time which included the Treatment Nurse. The IP stated the facility was not able to schedule a nurse to do treatments. The plan was for the nurses to apply the ointments and other nursing staff to fill in, to do the dressings on residents' wounds. The IP stated she did the wound care on one of the days without a Treatment Nurse. The IP stated that on 2/18/25, she did the rounding for the Wounds Assessments with the wound care MD, and the wounds were stable or healing.</p> <p>During an interview on 2/20/25 at 3:00 p.m., Licensed Nurse A stated she did not do the dressings for wound care, but did do the ointments and creams that did not require a dressing.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/20/25 at 3:10 p.m., Licensed Nurse B stated she did not have time to do the dressings that were ordered. Licensed Nurse B stated she did ask the Assistant Director of Nursing to change a dressing but did not recall if had been done and acknowledged it had not been documented. Licensed Nurse B stated that one of her Residents, Resident 4, requested Licensed Nurse C to change his dressing, but she was not able to do it every day as ordered.</p> <p>During an interview on 2/20/25 at 3:20 p.m., Licensed Staff C stated they did not have a Treatment Nurse, but she was able to provide the wound care treatments to her residents, Resident 1 and Resident 3. Licensed Staff C stated, on her days off the residents' wounds were not treated because a Registry Nurse had her assignment and probably, assumed a Treatment Nurse would do the treatments.</p> <p>During a review of the facility's staffing sheets for 2/1/25 to 2/14/25 (three shifts) documented the assignments for the nurses. The top of the sheets had the names of the unit nurses and space for the MDS Nurse (nurse to assess and document the Minimum Data Set for Medicare, the Treatment Nurse and an extra nurse, assigned when residents needs were high. The staffing sheets for the facility from Saturday 2/1/25 through Thursday 2/13/25, indicated no Treatment Nurse was scheduled to work.</p>