

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 04/10/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621</p> <p>Based on interview and record review, the facility failed to ensure Licensed Nurses (LNs) administered medications to residents per physician's order for two residents (Resident 1 and Resident 2) of four sampled residents when LNs administered medications late.</p> <p>This finding had the potential to result in serious side and adverse effects to the residents receiving late medications.</p> <p>Findings:</p> <p>A review of an admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included palliative care (specialized medical care for people with serious illnesses which is focused on relieving suffering and improving quality of life) and malignant neoplasm of skin (skin cancer).</p> <p>A review of a facility document titled, Medication Audit Admin Report, dated 3/1/25 to 3/31/25 indicated:</p> <p>-On 3/1/25, propranolol (medication used to treat tremors) 60 milligrams (mg, a unit of measurement) was scheduled to be given at 12 p.m. It was documented as administered at 4:14 p.m.</p> <p>-On 3/1/25, methadone (medication used to treat chronic pain) 2.5 mg was scheduled to be given at 12p.m. It was documented as administered at 4:12 p.m.</p> <p>-On 3/2/25, gabapentin (medication used to treat nerve pain) and methadone, were scheduled to be given at 9 a.m. They were documented as administered between 10:47 a.m. to 10:48 a.m.</p> <p>A review of Resident 2's Medication Administration Record for April 2025, indicated Resident 2 was admitted to the facility on [DATE] with medical diagnoses which included Epilepsy (A brain disease which causes seizures).</p> <p>A review of a facility document titled, Medication Audit Admin Report, dated 4/1/25 to 4/10/25 indicated:</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
---	-------	-----------

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 04/10/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 4/1/25, ropinirole (medication used to treat Parkinson's Disease (a neurological disorder which affects movement)) 2 mg was scheduled to be given at 8 a.m. It was documented as administered at 9:43 a.m.</p> <p>-On 4/2/25, levetiracetam (medication used to prevent seizures) 1000 mg was scheduled to be given at 8 a.m. It was documented as administered at 9:13 a.m.</p> <p>-On 4/3/25, aspirin (medication used to prevent strokes (a blockage in the vessels that deliver oxygen to the brain and can lead to brain damage) 81 mg was scheduled at 8 a.m. It was documented as administered at 9:35 a.m.</p> <p>During an interview on 4/10/25 at 12:25 p.m., LN A stated nursing staff were assigned around 30 residents per shift, including morning shift. LN A medications were administered up to one hour late to the residents because of the staffing shortage. LN A stated this was a result of the high number of resident assignments per nurse.</p> <p>During an interview on 4/10/25 at 1:02 p.m., LN B stated the facility was extremely short-staffed for LNs after approximately eight LNs had resigned simultaneously in January of 2025 when management decided to switch from twelve-hour shifts to eight-hour shifts. LN B stated since the change, a typical assignment ranged from 28 to 34 residents during morning shift per LN. LN B stated this made it impossible to administer all the resident medications timely. LN B stated management assigned only three nurses on the floor to provide direct resident care for a census of around 90 residents.</p> <p>During an interview on 4/10/25 at 1:30 p.m., Resident 2 stated medications were often administered late. Resident 2 stated receiving her medications late made her very anxious because she had restless leg syndrome, and when not given her medications timely, she was in a lot of discomfort.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:01 p.m., the Director of Nursing (DON) reviewed the Medication Audit Admin Reports for Resident 1 and Resident 2 and confirmed the medications were documented as administered late. The DON also reviewed the staffing sheets from February 23, 2025 through March 2, 2025, and April 3, 2025, through April 7, 2025, and confirmed the facility [AD8] had not met the State staffing requirements. The DON stated she herself would not be able to administer all the resident medications timely with such heavy resident assignments.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:25 p.m., LN C reviewed the Medication Audit Admin Report for Resident 1 and confirmed Resident 1's medications were administered more than one hour after the scheduled time. LN C confirmed the medications were administered late. LN C stated the facility was very short-staffed on LNs and resident assignments were so heavy it was impossible to administer all resident medications timely. LN C stated, We need more help.</p> <p>A review of the facility's policy titled, Medication-Administration, last revised in January of 2012, indicated, The Licensed Nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time.</p>		