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	01/29/2026

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 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. Based on interview and record review, the facility failed to ensure one (Resident 1) of nine sampled residents was free from abuse when Resident 1 became the victim of an alleged abuse event.This failure had the potential to negatively impact the resident's psychosocial well-being.A review of Resident 1's admission record indicated he was admitted in October 2025 with the diagnosis of encounter for palliative care (specialized medical care for individuals living with serious, chronic or life threatening illness that focuses on providing relief from the symptoms, pain and stress), acute chronic systolic (congestive) heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), muscle weakness, hearing loss and absence of left leg, below the knee.A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/10/26, indicated Resident 1 had slight memory impairment.In an interview, on 1/29/26 at 10:41 a.m. the Director of Nursing (DON) stated the facility substantiated the allegation of abuse and CNA 1 was terminated from her position. A review of a Termination Request email dated 1/12/26 at 12:30 p.m. by the Administrator and written to the corporate office stated, I am requesting to terminate employee [CNA 1] for abuse. The employee was overheard while providing a shower to a resident yelling and swearing. The resident was visibly bothered upon the interview. An interview on 1/29/26 at 1:21 p.m. with Resident 1, Resident 1 stated CNA 1 yelled and sweared [sic] at him and he did not like how he was treated.A review of Resident 1's care plan, dated 1/12/26 indicated Resident 1 was a victim of alleged abuse secondary to CNA [1] yelling at him when in the shower and calling him an asshole. During a review of the facility's policy titled, Abuse Prevention and Management, effective 2024, the policy stipulated, The facility does not condone any form of resident abuse., include[ing] verbal abuse. Verbal abuse is defined as any use of oral, written, gestured communication, or sounds that willfully includes despairing and derogatory terms directed to resident.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse policy for one (Resident 1) of nine sampled residents when a licensed nurse did not immediately document an assessment and conduct 72-hour monitoring for Resident 1 after an alleged abuse incident.This failure had the potential to deny physician and family involvement in the residents' care and result in unmet nursing needs for the resident.A review of Resident 1's admission record indicated he was admitted in October 2025 with the diagnosis of encounter for palliative care (specialized medical care for individuals living with serious, chronic or life threatening illness that focuses on providing relief from the symptoms, pain and stress), acute chronic systolic (congestive) heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), muscle weakness, hearing loss and absence of left leg, below the knee.A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/10/26, indicated Resident 1 had slight memory impairment.In an interview on 1/29/26 at 10:41 p.m. with the Director of Nursing (DON), the DON confirmed she was aware of the allegation of abuse that occurred on 1/9/26. The DON stated she expected licensed nurses to have charted a Change of Condition (COC) on the resident's chart, documented when the MD and family were notified, updated the residents' care plan and monitor the residents for 72 hours after the alleged abuse incident. The DON further stated she also expected the Social Services Director (SSD) to follow-up with the resident and document what occurred during the conversation.In a concurrent interview and record review on 1/29/26 at 10:25 a.m., the DON confirmed the social services 72-hour checks were lacking and there was no assessment documented or progress notes.A review of the facility's undated Abuse Reporting and Documentation lesson plan indicated LNs were to, complete assessment. and skin assessment of alleged victim.notify MD. add to alert charting x [for] 72 hours with appropriate monitors in place for increased distress. LN to document psychosocial q [every] shift and Social Services to document psychosocial q [every] day. IDT [Interdisciplinary Team, a group of healthcare professionals from different fields who collaborate and coordinate a resident's care needs] to review allegations promptly. A review of the facility's policy titled, Abuse Prevention and Management, revised 5/30/24, indicated, the resident will be assessed by the licensed nurse for any physical injuries or emotional distress. Notify the physician and provide treatment as ordered.