

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/13/2025
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record review, the facility failed to ensure an RN (Registered Nurse) provided services at least 8 consecutive hours a day, 7 days a week for 6 days in the month of April 2025. This failure decreased the facility's potential to ensure qualified staff were present to conduct resident assessments, develop and evaluate plans of care, and administer medications that must be administered by an RN. Findings: A review of the facility's current license to operate issued by the California Department of Public Health (CDPH) indicated the facility had a license to operate 104 skilled nursing beds. A review of the Payroll Based Journal (PBJ) Staffing Data Report dated April 1-June 30, 2025, indicated an RN did not work at the facility on the following dates: 4/5/25, 4/6/25, 4/12/25, 4/13/25, 4/19/25, and 4/20/25. During an interview on 9/16/25 at 8:21 a.m., the Administrator (ADM) acknowledged the facility did not have RN coverage on the above listed dates as the facility was struggling to find RNs in April 2025. The ADM stated the facility was unable to admit residents with procedures only RNs could perform. A review of a facility policy and procedure (P&P) titled, Nursing Department- Staffing, Scheduling, & Postings, dated July 2018, indicated, The Facility will employ Nursing Staff that will be on duty in at least the number and with the qualifications required to provide the necessary nursing services for the residents admitted for care. If the facility is licensed for 100 or more beds, it will have. At least one Registered Nurse, awake and on duty, in the facility at all times, day and night, in addition to the DONS (Director of Nursing Service). The director of nursing service will not have charge nurse responsibilities.		

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to ensure allegations of abuse were reported to the California Department of Public Health (CDPH, the Department) within two hours and investigation summaries were submitted within 5 days of becoming aware of allegations of abuse for 11 residents (Resident 00, Resident 83, Resident 101, Resident 90, Resident 105, Resident 102, Resident 2, Resident 74, Resident 14, Resident 68, and Resident 65) of 28 sampled residents when:1. Resident 00 entered Resident 83 and Resident 101's room and started breaking their belongings, cursing profanities, and yelling at them;2. Resident 90 threw water at Resident 105;3. Resident 102 was allegedly yelled at by CNA 8 and was told she needed to stop peeing on herself;4. Resident 2 slapped Resident 74 on the hand;5. Resident 14 allegedly grabbed Resident 90 because he had called him 'dude';6. Resident 68 was instructed to urinate in her brief by CNA 4 when Resident 68 asked for assistance to use the restroom; and,7. Resident 65 was allegedly hurt by CNA 8 while providing personal care. These failures decreased the facility's potential to report suspicions of crime against residents and staff to appropriate entities and protect residents by conducting investigations of the alleged abuse. Cross reference F600. Findings:1. A review of a State of California Form 341 (SOC 341, a form to be completed by a person reporting an allegation of abuse) dated 4/14/25 indicated the Administrator (ADM) was notified that Resident 00 entered Resident 83 and Resident 101's room and started breaking their belongings, cursing profanities, and yelling at them on 4/13/25 at 10:43 p.m. A review of an electronic mail (e-mail) from the ADM to the Department dated 9/5/25 at 3:38 p.m. indicated the abuse between Resident 00, Resident 83, and Resident 101 was originally sent to an incorrect e-mail address that was not the Department's on 4/13/25 at 11:39 p.m. A review of the Department's message log indicated the investigation summary of the abuse between Resident 00, Resident 83, and Resident 101 was received on 9/8/25.2. A review of an SOC 341 dated 4/17/25 indicated the ADM was notified that Resident 90 and Resident 105 were involved in a resident-to-resident altercation on 4/17/25. A review of the Department's message log indicated the SOC 341 and investigation summary of the abuse between Resident 90 and Resident 105 were received on 9/8/25.3. A review of an SOC 341 dated 4/22/25 indicated the ADM was notified that Resident 102 reported that CNA 8 had yelled at her accusing her of urinating on herself on purpose and she needed to stop it. A review of the Department's message log indicated the SOC 341 and investigation summary of the alleged abuse between Resident 102 and CNA 8 were received on 9/8/25.4. A review of an SOC 341 dated 4/22/25 indicated Resident 2 allegedly hit Resident 74 on 4/22/25 at 5:45 p.m. and the ADM became aware of the incident on 4/22/25 at 5:50 p.m. A review of an e-mail from the ADM to the Department dated 9/5/25 at 3:28 p.m. indicated the incident of abuse between Resident 2 and Resident 74 had initially been reported to the Department by telephone message on 5/10/25 at 11:30 a.m. A review of the Department's message log on 9/12/25 showed no messages received by the facility on 5/10/25. A review of the facility's investigation folder of the incident of abuse between Resident 2 and Resident 74 was reviewed on 9/16/25. There was no documented evidence that the facility's investigation summary had been sent to the Department by 4/27/25.5. A review of the facility's investigation summary dated 5/16/25 indicated the ADM was notified of an allegation of abuse between Resident 14 and Resident 90 occurred on 5/11/25 at 4:30 p.m. A review of the Department's message log indicated notification of the allegation of abuse was received on 9/8/25 by way of the investigation summary.6. A review of an SOC 341 dated 8/7/25 indicated the ADM was notified that a Restorative Nursing Assistant (RNA) witnessed CNA 4 instruct Resident 68 to urinate in her brief when Resident 68 asked for assistance to use the restroom. A review of an e-mail from the ADM to the Department dated 9/5/25 at 3:21 p.m. indicated the abuse between CNA 4 and Resident 68 was originally sent to an incorrect e-mail address that was not the Department's on 8/7/25. A review of the Department's message log indicated the investigation (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	summary of the abuse between CNA 4 and Resident 68 was received on 9/8/25.7. A review of an SOC 341 dated 9/15/25 indicated the ADM was notified of the allegation of abuse between CNA 8 and Resident 65 on 9/15/25 at 3:30 p.m.In an interview on 9/15/25 at 4:37 p.m., Resident 65 stated she notified CNA 3 that CNA 8 had hurt her while providing care on the night of 9/14/25 between 11 p.m. and 7 a.m. Resident 65 stated she notified CNA 3 of her concern after breakfast earlier that morning on 9/15/25.In an interview on 9/17/25 at 8:43 a.m., Resident 49 stated she heard Resident 65 notify CNA 3 of her concern with CNA 8 after breakfast on 9/15/25.In an interview on 9/17/25 at 9:17 a.m., CNA 3 acknowledged Resident 65 had notified her CNA 8 had hurt her while providing her care on the night of 9/14/25. CNA 3 confirmed Resident 65 had notified her of CNA 8 after breakfast at around 9 a.m. CNA 3 stated she notified the Director of Staff Development after she ate her lunch on 9/15/25 at approximately 12 p.m.In an interview on 9/17/25 at 4:21 p.m., the ADM acknowledged she notified the Department of Resident 65's allegation of abuse on the afternoon of 9/15/25 at approximately 3:30 p.m. and had already interviewed Resident 65 about the allegation. The ADM stated she was unaware Resident 65 had initially reported the allegation of abuse to nursing staff on the morning of 9/15/25 after breakfast. The ADM also acknowledged she had submitted the notifications of the allegations of abuse and investigation summaries for Resident 00, Resident 83, Resident 101, Resident 90, Resident 105, Resident 102, Resident 2, Resident 74, Resident 14, Resident 68 late but stated she had done so because she had not realized the e-mail address she had sent the notifications to was incorrect.A review of the facility's policy and procedure titled Abuse Prevention and Management effective 6/12/24 indicated, .The facility conducts mandatory staff training during orientation, annually, and as needed on.Reporting abuse.to whom and when to report and to report without fear of reprisal.The Administrator or designated representative will notify law enforcement, by telephone immediately.but no longer than (2) hours of an initial report AND send a written SOC 341 report to.CDPH Licensing and Certification [the Department] within (2) hours.The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification [the Department].within five (5) working days of the reported allegation.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident and/or their Responsible Party (RP, an individual or entity who has the primary duty to make healthcare decisions) with a summary of the resident's baseline plan of care and list of medications for three residents (Resident 41, Resident 46, and Resident 96) of 28 sampled residents. This failure decreased the facility's potential to provide communication with the residents and/or their RP on how the facility planned to manage needed services and treatments while at the facility. Findings: A review of Resident 41's admission record indicated admission to the facility on 8/30/25, with diagnosis including Pneumonia (lung infection), Alcohol Dependence, Alcohol Use with Withdrawal, Type Two Diabetes (elevated sugar in the blood), and he was his own RP. A review of Resident 41's baseline care plan signed and dated by the Minimum Data Set Coordinator (MDSC) as completed on 9/3/25, indicated Resident 41 was provided with a current medication list and the section where Resident 41 was supposed to sign and date the document was blank. A review of Resident 41's Admitting MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 9/6/25, indicated a Brief Interview of Mental Status (BIMS, a cognitive assessment used in long-term care facilities) of 14 which meant Resident 41 was cognitively intact (the ability to clearly think, learn, and remember). During an interview on 9/17/25 at 11:01 a.m., Resident 41 could not recall if a nurse had reviewed his baseline care plan and his list of medications with him and given him copies within 48 hours of being admitted. A review of Resident 46's admission record indicated admission to the facility on 8/15/25, with diagnosis including Metabolic Encephalopathy (problems with your metabolism cause brain dysfunction), Wernicke's Encephalopathy (a severe brain disorder caused by a deficiency of Vitamin B1), Malignant Neoplasm (cancer) of Rectum (the final section of your large intestine), and she was her own RP. A review of Resident 46's baseline care plan signed and dated by the MDSC as completed on 8/20/25 indicated Resident 46 was provided with a current medication list and the Representative signature and date were left blank. A review of Resident 46's MDS, dated [DATE], indicated Resident 46 had a BIMS of 15 which indicated she was cognitively intact. During an interview on 9/15/25 at 11:27 a.m., Resident 46 stated the communication amongst the staff was very bad. Resident 46 could not recall if a nurse had reviewed her baseline care plan and her list of medications with her and given her copies within 48 hours of being admitted. A review of Resident 96's admission record indicated admission to the facility on 9/5/25, with diagnosis including Epileptic Syndrome (a temporary disruption of the brain's normal electrical activity, causing a temporary and involuntary change in body movement, sensation, awareness, or behavior), Type Two Diabetes, and Unspecified Intestinal Obstruction, and he was his own RP. A review of Resident 96's Admitting MDS, dated [DATE], indicated Resident 96 had a BIMS of 14 which indicated he was cognitively intact. A review of Resident 96's baseline care plan signed and dated by the MDSC as completed on 9/12/25 indicated Resident 96 was provided with a current medication list and the Representative signature and date were blank. During an interview on 9/15/25 at 10:14 a.m., Resident 96 stated he had been on some new seizure medications at the hospital that wrecked him. Resident 96 stated he ended up in the Intensive Care Unit (ICU) because he became delusional (a false belief that something is real) and paranoid (suspicious, or mistrustful of others). Resident 96 stated the nurses at this facility were trying to give him the same three seizure medications, but he refused the medication. Resident 96 stated he thought someone reviewed his medications with him, but he did not receive a copy of the list of medications ordered for him. During a concurrent interview and record review of Resident 41's, Resident 46's, and Resident 96's baseline care plans on 9/17/25 at 10:40 a.m., the MDSC stated there was not an option for a resident and/or their RP to sign and date the Baseline Care Plan electronically which was why the signature area was (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left blank. The MDSC stated the nurse should have documented when the nurse reviewed the baseline care plan in a progress note that the baseline care plan and the resident's list of medications had been reviewed with the resident and/or RP and a copy was given to the resident and/or RP. The MDSC stated one needed to document it in the resident's chart to show it was done.A review of the facility's Policy/Procedure titled, Comprehensive Person-Centered Care Planning, revised on 8/24/23, indicated: .Baseline Care Plan Summary.The baseline care plan summary will be developed within 48 hours of admission.The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to.Initial goals of the resident.A summary of the resident medications and dietary instructions.Any services and treatments provided to the resident.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop comprehensive care plans for four residents (Resident 62, Resident 41, Resident 46, and Resident 96) of 28 sampled residents when:1. Care plans were not developed for care areas identified by Resident 62's Minimum Data Set (MDS- a federally mandated resident assessment tool); and,2. Discharge care plans were not developed for newly admitted residents (Resident 41, Resident 46, and Resident 96), after their initial multidisciplinary care conference. These failures decreased the facility's potential to meet residents' nursing needs and ensure safe discharges. Findings:1. A review of Resident 62's admission record indicated a readmission to the facility on 7/8/25, with diagnosis including Discitis (an infection and swelling of the spongy, cushion-like disc between the bones in your spine (backbone)), Osteomyelitis (a bone infection caused by bacteria or other microorganisms), back pain, Congested Heart Failure (progressive condition where the heart muscle weakens and can no longer pump blood effectively), Type Two Diabetes (high blood sugar), Legal Blindness, Obstructive Sleep Apnea (a disorder where throat muscles relax during sleep, causing the airway to repeatedly block, leading to pauses in breathing), and Moderate Protein Calorie Malnutrition (when an individual does not consume enough protein to meet their physiological needs). A review of Resident 62's MDS, dated [DATE], indicated Resident 62 was on oxygen therapy (medical treatment that provides extra oxygen to people who can't get enough on their own) and was doing active range of motion exercises and receiving splint brace assistance per a Restorative Nursing Program (includes active, goal-oriented techniques such range-of-motion exercises to maintain joint mobility). A review of Resident 62's order summary report, dated September 2025, indicated Resident 62 was to have two to four Liters (a metric unit of volume) of Oxygen (O2) per nasal cannula (medical device consisting of a small tube with two prongs that fit into the nostrils to deliver supplemental oxygen) starting on 7/10/25, and an RNA (Restorative Nursing Assistant, a person who received specialized training in rehabilitative and restorative care program) to perform Active Range of Motion to bilateral upper and lower extremities 5 times per week as tolerated and splint to left and right hand 5 times per week as tolerated starting on 9/4/25. A review of Resident 62's care plans indicated no documented evidence of a care plan initiated to reflect Resident 62's need for O2 and RNA services. During an interview on 9/17/25 at 4:41 p.m., the Director of Rehab (DOR) stated because Resident 62 was not advancing with her Physical Therapy (PT), PT was discontinued, and Resident 62 was placed in the RNA program. The DOR stated the nurse was responsible for obtaining the RNA orders from the physician based on the DOR's recommendations and initiated the RNA care plan. During an interview on 9/18/25 at 9:15 a.m. the MDS Coordinator (MDSC) stated Resident 62 should have had a care plan addressing her order to receive services from the RNA Program. The MDSC stated the Director of Nursing (DON) should have updated Resident 62's care plan. During an interview on 9/18/25 at 9:20 a.m., the DON acknowledged she should have developed an RNA care plan for Resident 62. During a concurrent interview and record review on 9/18/25 at 11:31 a.m., the MDSC reviewed Resident 62's latest MDS, dated [DATE], and Resident 62's care plans. The MDSC acknowledged Resident 62 did not have a care plan initiated for the use of O2 and should have had one. 2. A review of Resident 41's admission record indicated admission to the facility on 8/30/25, with a diagnosis including Pneumonia (lung infection), Alcohol Dependence, Alcohol Use with Withdrawal, and Type Two Diabetes. A review of Resident 41's baseline care plan signed and dated by the MDSC indicated it was completed on 9/3/25. A review of Resident 41's progress note dated 9/4/25 at 10:54 a.m., indicated Resident 41 had his initial care conference on 9/4/25 at 11:20 a.m. A review of Resident 41's multidisciplinary care conference, effective date 9/4/25, indicated, [Resident 41] states his trailer is infested with rats and due to that he has been living on the streets. [Resident 41's] Expectation is to return to the community after he (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is done with therapy, and to find safe housing. This document also indicated that the Social Service Director (SSD) was going to reach out to multiple programs in the community to see what resources were available for Resident 41.A review of Resident 46's admission record indicated admission to the facility on 8/15/25, with diagnosis including Metabolic Encephalopathy (problems with your metabolism cause brain dysfunction), Wernick's Encephalopathy (a severe brain disorder caused by a deficiency of Vitamin B1), and Malignant Neoplasm (cancer) of Rectum (the final section of your large intestine.A review of Resident 46's baseline care plan signed and dated by the MDSC indicated it was completed on 8/20/25.A review of Resident 46's multidisciplinary care conference effective date 8/19/25, indicated the social service and Resident/Family Expectation/Concerns were both blank. There was no indication of Resident 46's discharge plans.A review of Resident 96's admission record indicated admission to the facility on 9/5/25, with diagnosis including Epileptic Syndrome (seizure type: a temporary disruption of the brain's normal electrical activity, causing a temporary and involuntary change in body movement, sensation, awareness, or behavior), Type Two Diabetes, and Unspecified Intestinal Obstruction.A review of Resident 96's baseline care plan signed and dated by the MDSC indicated it was completed on 9/12/25.A review of Resident 96's social service assessment, dated 9/8/25 at 8:10 a.m., indicated there was an active discharge plan in place for Resident 96 to return to the community. Resident 96's goal was to get stronger in the facility with the help of nursing so Resident 96 could return to the community with the support from IHSS (In-home Support Services) and PACE (Program of All-Inclusive Care for the Elderly: Medicare (United States health insurance program) and Medicaid (provides coverage for low-income people) programs.A review of Resident 96's social service progress note dated 9/8/25at 8:23 a.m., indicated Resident 96 had his initial care conference set for 9/8/25 at 11:30 a.m. with Resident 96's friend attending too.A review of Resident 96's multidisciplinary care conference effective date 9/8/25, indicated, Resident is a PACE patient and current issues is he needs to get back to baseline so he can return home with minimal support from PACE and his friends.[Resident 96's] Expectation is to get back to his baseline with the help of therapy and nursing, so he can return home with minimal support from his friends and PACE caregiver.During an interview and concurrent record review on 9/17/25 at 12:45 p.m., the SSD stated a social service assessment should be completed for a new admission within two days of the resident being admitted to the facility. The SSD stated it looked like Resident 41's social service assessment had not been completed yet. The SSD stated Resident 41 was homeless and the SSD was trying to find him a place to live. The SSD stated he did not know Resident 41 wanted to be moved to a facility in Eureka to be closer to his family member. The SSD stated a resident's discharge care plan should be completed or updated after the Interdisciplinary Team (IDT: healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a resident) completed their initial care conference with the resident or the RP. The SSD reviewed Resident 41's care plans which indicated no discharge care plan had been initiated. The SSD reviewed Resident 46's social service assessment and stated the discharge plans section had not been completed. A review of Resident 46's care plans indicated a discharge care plan had not been initiated after Resident 46's initial care conference which took place on 8/19/25. A review of Resident 96's care plans indicated a discharge care plan had not been initiated after Resident 96's initial care conference which took place on 9/8/25.The facility policy/procedure titled, Comprehensive Person-Centered Care Planning, revision 8/24/23, indicated, The Facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.Comprehensive Care Plan.In consultation with the resident and the resident's representative.The resident's preference and potential for future discharge. Facilities must document whether the residents desire to return to the community was assessed and any referrals to local contract agencies and/or other appropriate entities, for this purpose.Discharge plans in the conference of care plan, as appropriate.The facility (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	job description titled, Social Service Coordinator, not dated, indicated, .Clinical/Administrative.Assist with discharge planning, Implement and updated Resident Care Plan and Social History.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications in medication carts (med carts) were stored in a clean, safe and orderly manner, when:1. Crushed and loose medications were stored in Med Cart 4; and,2. One med cart (Med Cart 1) was left unlocked when unattended.These failures had the potential for residents, visitors or unauthorized personnel to access medications, and unwanted exposure or cross contamination of medications when they were in an unsanitary manner. Findings:1. During a concurrent observation and interview on 9/16/25 at 3:20 p.m. with Licensed Nurse 4 (LN 4), at Med C art 4, the following was observed:a. One 30 milliliter (ml, a unit of measurement) plastic medication cup which contained a brown chunky substance was stored in the top drawer; and, b. One loose capsule and 8.5 loose tablets were found in various drawers.LN 4 stated the plastic medication cup contained crushed medications mixed with chocolate pudding and had been prepared for resident administration earlier that morning. LN 4 confirmed, No, I'm never supposed to leave prepared medications in the cart. LN 4 acknowledged loose pills should have been removed from the med cart to ensure the cart was kept in a clean and orderly manner. 2. During a concurrent observation and interview on 9/17/25 at 2:40 p.m. at Nursing Station 1, Med Cart 1 was observed unlocked and unattended. LN 3 returned to Med Cart 1 and confirmed the cart was unlocked and unattended. LN 3 stated med carts should be locked when unattended to ensure the safety of the medications and prevent unauthorized access. During a concurrent observation and interview on 9/17/25 at 4:54 p.m. with the Director of Nursing (DON) and the Director of Staff Development (DSD) Med Cart 1 was observed unlocked and unattended in the hallway outside of room [ROOM NUMBER]. The DON and DSD confirmed Med Cart 1 was unlocked and unattended and that med carts should be locked when unattended to prevent unauthorized access to the medications. During an interview on 9/18/25 at 10:39 a.m., the DON confirmed residents' prepared medications should not be stored in the med cart and loose pills should be removed. The DON stated if a resident refused the prepared medications the LN should have documented the refusal, notified the physician and discarded the medication per facility policy. The DON stated med carts should be maintained in a clean and sanitary manner. A review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility revised January 2018, indicated, Medications and biologicals are stored safely, securely and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Medication rooms, carts and medication supplies are kept locked when not attended by persons with authorized access.Medication storage areas are kept clean.		

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NAME OF PROVIDER OR SUPPLIER Fortuna Rehabilitation and Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 Newburg Road Fortuna, CA 95540	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to honor the food preferences for three residents (Residents 14, 46, and 97) of 28 sampled residents. These failures resulted in Residents 14, 46, and 97 feeling ignored and frustrated as they were served food they disliked, which may lead to poor nutritional intake and unplanned weight loss. Findings: A review of Resident 46's admission record indicated Resident 46 was admitted to the facility on [DATE], with diagnosis including Malignant Neoplasm (cancer) of Rectum (the final section of your large intestine). A review of Resident 46's Nutritional Risk Assessment effective date 8/21/25, indicated Resident 46 did not like raw fruits and vegetables. A review of Resident 46's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/22/25, indicated Resident 46 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 15 (cognitively intact). During an interview on 9/15/25 at 11:27 a.m., Resident 46 stated the facility needed better cooks. Resident 46 stated she had never seen the Registered Dietician (RD) or the Certified Dietary Manager (CDM). Resident 46 stated she knew she was not supposed to have raw vegetables and fruits, but she continues to receive raw fruits and vegetables on her meal trays. Resident 46 stated the kitchen would send out menus to choose from, but Resident 46 stated she did not always get everything she asked for. A review of Resident 46's breakfast, lunch and dinner meal cards indicated Resident 46's dislikes, which included No Fresh Fruit, only canned for all three meals. Resident 46's lunch and dinner meal cards indicated Resident 46's dislikes, which included asparagus, brussel sprouts, garlic, onions, peas, corn, spinach, broccoli, lima beans, salads and raw vegetables. During a concurrent observation of the kitchen tray line and the resident meal cards on 9/16/25 at 5:45 p.m., Resident 14's dinner plate was plated with mixed vegetables, which included carrots. Resident 14's dinner meal card indicated Resident 14 disliked carrots. During a concurrent observation of the kitchen tray line and the resident meal cards on 9/16/25 at 5:45 p.m., Resident 97's dinner plate was plated with a mixed vegetable which included cauliflower. Resident 97's dinner meal card indicated Resident 97 disliked cauliflower. During a concurrent observation and interview on 9/16/25 at 6:30 p.m., Resident 14 was asked how he felt about receiving carrots on his dinner plate. Resident 14 stated he did not like the carrots because he did not like how the cook cooked carrots, too soft. Resident 14 stated he would not eat the carrots because of how the carrots were cooked; Resident 14 stated the carrots had the same texture as baby food. During a concurrent observation and interview on 9/16/25 at 6:30 p.m., Resident 97 was asked how she felt about being served cauliflower for dinner. Resident 97 stated she just picked the cauliflower out of the mixed vegetable. During an interview on 9/16/25 at 7 p.m., the Regional RD (RRD) stated the residents should not have been served carrots and/or cauliflower if the food items were specified as dislikes on the resident's meal card. The RRD stated corn, and peas were prepared for those who did not like the mixed vegetables. The RRD stated when the Dietary Aide 1 (DA 1) called out the resident's diet, DA 1 needed to make sure the [NAME] did not plate a disliked food item. The RRD stated DA 1 should have checked the plate against residents' meal cards to make sure dislikes were not placed on the resident's meal tray. During an interview on 9/18/25 at 4:17 p.m., the RD stated it would be the CDM (Certified Dietary Manager) who would make sure residents' food preferences were being honored and updated accordingly. The RD stated the CDM would interview the resident upon admission and address the resident's food likes and dislikes. The facility Policy/Procedure titled, Dietary Profile and Resident Preference Interview, revised 4/21/22, indicated, Purpose: To ensure that residents are properly evaluated for dietary needs on an ongoing basis. Policy: The Dietary Manager will complete a Dietary Profile for residents to reflect current nutritional needs and Food Preferences. Additional documentation of nutritional needs/food (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferences between the Dietary Profile's should be documented on the progress note.The Dietary Manager will complete a Dietary Profile for residents within 72 hours of admission to capture and update information regarding nutritional needs and preferences.Resident Preferences will be reflected in the medical record and tray-card and updated in a timely manner. The Dietary Department will provide residents with meals consistent with their preferences and Physician order as indicated on the tray card.If a preferred item is not available, a suitable substitute should be provided .The Dietary Manager may update food preferences as often as necessary .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews and record review the facility failed to ensure sanitary conditions were maintained and failed to follow Standard Precautions (proper cleaning and disinfection of equipment) for a census of 94 residents, when: 1. Resident 1's bedside commode (BSC, a portable toilet) was not kept in a clean and sanitary manner; 2. The metal ice scoop on the hydration cart was not stored in a sanitary manner; and, 3. Staff did not disinfect the vital sign machine and equipment between use for five residents (Residents 83, Resident 77, Resident 82, Resident 28, and Resident 88). These failures decreased the facility's potential to prevent the spread of infection and pathogens (microorganisms or other biological agents that can cause disease) between residents. Findings: 1. A review of Resident 1's admission record indicated admission to the facility in December 2023 with diagnoses which included muscle weakness and unstable gait and mobility. During an observation on 9/15/25 at 9:35 a.m. in Resident 1's room, a BSC was observed positioned next to Resident 1's bed. The BSC had a brown splattered substance streaked on the top and backside of the seat and on the armrests. During a concurrent observation and interview on 9/15/25 at 1:42 p.m. with Certified Nursing Assistant 5 (CNA 5), in Resident 1's room, Resident 1's BSC was observed. CNA 5 acknowledged the BSC was soiled and needed to be cleaned. CNA 5 stated the BSC should have been cleaned and disinfected after each use. During an observation on 9/16/25 at 8:15 a.m. in Resident 1's room, the BSC was observed soiled and streaked with a brown substance on the top and backside of the seat and on the armrests. During an interview on 9/16/25 at 12:47 p.m. with Resident 1, in the resident's room, Resident 1 was seated in the recliner next to the bed. Resident 1 confirmed he used the BSC and expected it to be cleaned and ready to go for the next time it needed to be used. During a concurrent observation and interview on 9/16/25 at 12:58 p.m. with the Infection Preventionist (IP), in Resident 1's room, Resident 1's BSC was observed. The IP acknowledged Resident 1's BSC was soiled and needed to be cleaned and disinfected. The IP stated the BSC should have been cleaned and disinfected after each use. During an interview on 9/17/25 at 3:19 p.m. the Director of Nursing (DON) stated the BSC should have been cleaned after each use for sanitary reasons. The DON stated each resident had the right to access clean and sanitary equipment. The DON stated a clean and sanitary environment decreased the potential for the spread of illness and maintained the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Commode & Cleaning revised January 2012, indicated, To provide a sanitary environment for residents on who bedside commodes are used. Bedside commodes are sanitized after every use. The commode is removed from the resident's bedside area and taken to be sanitized. The commode is wiped thoroughly with a disinfectant wipe. 2. During an observation on 9/15/25 at 9:23 a.m. in the Lytle hallway, the metal ice scoop on the mobile hydration station was observed exposed and accessible to anyone. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/15/25 at 12:44 p.m., in the dining room, the ice scoop on the mobile hydration station was observed exposed and accessible to anyone. During a concurrent observation and interview on 9/16/25 at 12:57 p.m. with the IP, in the Lytle hallway, the exposed ice scoop on the hydration station was observed. The IP confirmed the ice scoop should have been kept in a plastic bag to protect it and the ice from various pathogens (microorganisms or biological agents that can cause disease) and contamination. During an interview on 9/17/25 at 3:30 p.m. the DON acknowledged the ice scoop should not be left out in the open. The DON stated an ice scoop stored open to air increased the potential for illnesses to spread to vulnerable residents. The DON stated the ice scoop should have been kept in a clean, closed container when not in use. During a review of the facility's P&P, titled, Ice Machines and Ice Storage Chests revised October 2014, indicated, Ice machines and ice storage/distribution containers are used and maintained in a manner that provides a safe and sanitary supply of ice. To help prevent contamination of ice storage chest/containers or ice, Facility Staff take the following precautions. Keeps the ice scoop/bin in a covered container when not in use. 3. During an observation on 9/15/25 at 10:55 a.m. in the room Resident 77 and Resident 83 shared, CNA 4 was observed obtaining vital signs for Resident 77 with a vital sign machine. After completing measurements for Resident 77, CNA 4 proceeded to obtain the vital signs of Resident 83 with the same machine without disinfecting the equipment between residents. At 11:21 a.m., CNA 4 was then observed proceeding to the room of Resident 82, Resident 28, and Resident 88. CNA 4 was observed obtaining vital signs of Resident 82. CNA 4 did not disinfect the machine before or after obtaining the vital signs of Resident 82. CNA 4 was observed obtaining the vital signs of Resident 28 and Resident 88 without disinfecting the machine after or before each use. During an interview on 9/15/25 at 1:40 p.m. CNA 4 acknowledged he/she obtained vital signs for Residents 82, 28, 88, 77, and 83. CNA 4 also acknowledged he/she did not disinfect the vital signs machine and equipment between residents. CNA 4 stated cleaning medical equipment between patient contact is the expectation and that not doing so can lead to the spread of infections between residents. During an interview on 9/16/25 at 10:20 a.m. the Infection Prevention nurse (IP) stated staff were expected to clean equipment in between residents to prevent the transmission of infections through indirect contact. During an interview on 9/16/25 at 12:46 p.m. the Director of Nursing (DON) stated staff were expected to disinfect equipment after using it on a resident to prevent the risk of spreading infection to others with contaminated equipment. During a review of The Center of Disease Control and Prevention's (CDC-a United States government agency for public health and disease prevention that provides national guidance, research, and public health interventions) Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 updated on June 2024, indicated, Perform low-level disinfection for noncritical patient-care surfaces (e.g., bedrails, over-the-bed table) and equipment (e.g., blood pressure cuff) that touch intact skin.[and] Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant . after use on a patient who is on contact precautions before using this equipment on another patient.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for a census of 94 residents when flies were observed flying throughout the facility. This resulted in residents being bothered by flies in their room, flies in the Great Dining Room while residents were trying to eat their meals, and flies in the kitchen which could lead to contamination of food being prepared. Findings: During a dining room observation on 9/15/25 at 12:45 p.m., the door leading from the dining room to the outside resident patio was wide open during lunchtime without any screens to prevent pests from entering. Flies were noted in the dining room. A picture of a fly on a resident's arm and a picture of a fly on the resident coffee dispenser was taken during the lunch meal. During an observation on 9/15/25 at 5:31 p.m., three flies were continuously buzzing around while Resident 14 swatted at them. During a concurrent observation and interview on 9/16/25 at 2:40 p.m., both the Regional Registered Dietician (RRD) and the Certified Dietary Manager (CDM) stated flies in the kitchen were an infection control issue especially if landing on food prep countertops and food. Two flies were observed flying in the kitchen. During an observation on 9/16/25 at 10:45 a.m., two flies were in Resident 65's room bothering Resident 65. The flies were touching her face as she was trying to brush the flies away from her. During a concurrent interview and record review of the most recent Pest Control receipt on 9/17/25 at 9:15 a.m., the fly issue in the kitchen, Garden Dining Room, resident rooms, and nurse's station was addressed to the Administrator (ADM). The ADM stated for the past two days the weather had been warm, which had brought flies. The Surveyor pointed out to the ADM the Garden Dining Room door leading to the residents' patio had been left open and there was no screen door, leading to easy access for flies to enter the facility. Flies had easy access to the kitchen because the entrance door to the kitchen was accessed through the Garden Dining Room. During an observation on 9/18/25 at 9:15 a.m., the Garden Dining Room door leading to the resident patio was wide open and there was no screen door. A resident was sitting in a chair located in the Garden Dining Room, against the wall, left of the open door. A fly was flying around the resident. A review of the facility's Policy/Procedure titled, Pest Control, revised 1/1/12, indicated, Purpose: To ensure the Facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, Facility Staff and visitors. Policy: The Facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects, rodents, and other pests.		

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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 interview and record review, the facility failed to ensure five residents (Resident 74, Resident 83, Resident 101, Resident 105, and Resident 68) of 28 sampled residents were free from abuse when:1. Resident 2 slapped Resident 74 on the hand;2. Resident 00 entered Resident 83 and Resident 101's room and started breaking their belongings, cursing profanities, and yelling at them;3. Resident 90 threw water at Resident 105; and,4. Certified Nursing Assistant 4 (CNA 4) instructed Resident 68 to urinate in her brief when Resident 68 asked for assistance to use the restroom.These failures resulted in residents being hit, feeling fear, and being neglected.Findings:1. A review of Resident 2's admission record indicated admission to the facility on 2/20/24 with diagnoses which included metabolic encephalopathy (a change in the brain's function due to an underlying condition), dementia (a progressive state of decline in mental abilities), cerebral infarction (also known as a stroke, when blood flow to the brain is interrupted, which causes brain cells to die), and cognitive communication deficit (difficulty in communication caused by impaired brain function).A review of Resident 2's Minimum Data Set (MDS, an assessment tool) dated 2/27/25 indicated a Brief Interview for Mental Status (BIMS, a screening tool used to assess a resident's cognition (the mental process of acquiring knowledge, understanding, and awareness through the thought process)) score of 6 which meant Resident 2 was severely cognitively impaired.A review of Resident 74's admission record indicated admission to the facility on [DATE] with diagnoses which included subdural hemorrhage (when blood pools between the brain and its outermost covering usually caused by a head injury), encephalopathy (a brain disease that alters brain function which can be caused by a stroke), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and cognitive communication deficit.A review of Resident 2's change in condition evaluation dated 4/22/25 at 7:57 p.m. indicated, [Resident 2] Slapping another patient [Resident 74].A review of Resident 74's change in condition evaluation dated 4/22/25 at 8:12 p.m. indicated, [Resident 74] got slapped on hand by another patient.A review of Resident 2's psychosocial note dated 4/23/25 at 1:27 p.m. indicated, This writer asked resident what happened. Resident replied, ?My back was hurting, and she was irritating me'.In an interview on 9/16/25 at 1:34 p.m., the Activities Assistant (AA) stated he witnessed Resident 2 hit Resident 74 when they were sitting in their wheelchairs in front of Nurse's Station 1. The AA stated Resident 2 did not hit Resident 74 hard, but that it did happen.2. A review of Resident 00's admission record indicated admission to the facility on [DATE] with diagnoses which included psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition and dementia with behavioral disturbance.A review of Resident 00's MDS dated [DATE] indicated a BIMS score of 6 which meant Resident 00 was severely cognitively impaired.A review of Resident 101's admission record indicated admission to the facility on 3/25/25 with diagnoses which included chronic heart failure, chronic hepatic (kidney) failure, and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life).A review of Resident 101's MDS dated [DATE] indicated a BIMS score of 12 which meant Resident 101 was moderately cognitively impaired.A review of Resident 83's admission record indicated admission to the facility on 3/13/23 with diagnoses which included aphasia (a disorder that makes it difficult to speak), recurrent major depressive disorder (a mental health disorder characterized by persistent feelings or sadness, hopelessness, and loss of interest or pleasure in activities), and anxiety disorder.A review of Resident 83's MDS dated [DATE] indicated a BIMS score of 9 which meant Resident 83 was moderately cognitively impaired.A review of Resident 00's Situation, Background, Assessment, and Recommendation (SBAR) summary for providers note dated 4/13/25 at 11:40 p.m. indicated, resident had increased behaviors including hitting, throwing objects, screaming and yelling.A review of (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 83's psychosocial note dated 4/14/25 at 11:08 a.m. indicated, F/U [Follow up] with resident when this writer asked resident about incident with other resident.[Resident 00] she replied, 'I'm scared of her she broke my TV I don't want her in my room'.A review of Resident 00's psychosocial note dated 4/14/25 at 11:20 a.m. indicated, F/U with resident this writer asked Why did you go in their room Resident replied 'Because they are stupid and they keep bugging me and the TV was up loud I told them to quit talking and they did not'.A review of Resident 101's Interdisciplinary Team (IDT, a group of professionals with different areas of expertise who collaborate to address a resident's care needs) progress note dated 4/14/25 at 12 p.m. indicated, IDT Team followed up on incident from 4/13/25, [11:20 p.m.].When asked about the incident from last night, Patient expressed Anxiety over the other Resident coming back into her Room.A review of Resident 83's psychosocial note dated 4/15/25 at 8:35 a.m. indicated, .This writer asked if resident feels safe Resident replied 'Yes I don't want that lady [Resident 00] in my room ever ever [sic] again'.In an interview on 9/16/25 at 4:48 p.m., CNA 1 stated she heard screaming in Resident 101 and Resident 83's room. When CNA 1 entered the room, she saw Resident 00 leaning over Resident 101 and screaming in her face. CNA 1 stated Resident 00 looked like she was about to choke Resident 101 and Resident 101's eyes looked like she was terrified. CNA 1 stated she tried to separate Resident 00 from Resident 101, but Resident 00 was resisting and grabbing onto Resident 101 and Resident 83's belongings. CNA 1 stated it was a really scary situation for her so it must have been terrifying for Resident 101.3. A review of Resident 90's admission record indicated admission to the facility on 9/4/25 with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and autistic disorder (a lifelong neurological and developmental condition affecting social interaction, communication, learning, and behavior).A review of Resident 90's MDS dated [DATE] indicated a BIMS score of 7 which indicated Resident 90 was severely cognitively impaired.A review of Resident 105's admission record indicated admission to the facility on 5/14/25 with diagnoses which included Alzheimer's disease and congestive heart failure.A review of Resident 105's MDS dated [DATE] indicated a BIMS score of 5 which indicated Resident 105 was severely cognitively impaired.A review of Resident 90's progress note dated 4/16/25 at 8:45 p.m. indicated a CNA heard yelling in Resident 105 and Resident 90's room. When she entered the room, Resident 105 stated Resident 90 had thrown water at him. It was documented that water was observed on the floor and Resident 105's clothing was wet.A review of the facility's investigation summary dated 4/22/25 indicated an altercation between Resident 90 and Resident 105 had occurred which involved Resident 90 throwing water and dishes at Resident 105.In an interview on 9/17/25 at 12:05 p.m. Resident 90 confirmed he had thrown water at his roommate and stated he had done so because he pissed me off.4. A review of Resident 68's admission record indicated admission to the facility on 8/8/25 with diagnoses which included dementia, depression, and cognitive communication deficit.A review of Resident 68's MDS dated [DATE] indicated a BIMS score of 4 which meant Resident 68 was severely cognitively impaired.A review of Resident 68's SBAR summary for providers dated 8/8/25 at 10:19 a.m. indicated, Staff overheard CNA [4] telling [Resident 68] to pee in her pants. RNA [Restorative Nursing Assistant] intervened and too [sic] resident to the bathroom.In an interview on 9/16/25 at 2:41 p.m., RNA stated Resident 68 had been in the dining room with several other residents and CNA 4. Resident 68 had repeatedly asked CNA 4 for assistance to go to the bathroom when the RNA heard CNA 4 instruct Resident 68 to go to the bathroom in her brief. RNA thought it was inappropriate, so she took Resident 68 back to her bedroom and assisted her to go to the bathroom.A review of the facility's policy and procedure titled Abuse Prevention and Management revised 5/30/24 indicated, The Facility does not condone any form of resident abuse, neglect.and/or mistreatment.'Verbal abuse' is define as any use of oral.gestured communication, or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, regardless of.ability to comprehend.'Physical abuse' is defined (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as, but not limited to.hitting, slapping, punching, and/or kicking.'Neglect' and ?deprivation of.services by staff' are defined as failure to provide.services necessary to attain or maintain physical, mental, and psychosocial well-being.		

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 11/13/2025
NAME OF PROVIDER OR SUPPLIER Fortuna Rehabilitation and Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 Newburg Road Fortuna, CA 95540	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that one of eight sampled residents, (Resident 2) was free of unnecessary psychotropic medications (drugs that affect the mind and brain, altering mood, perception, and behavior) when Resident 2 received: Haloperidol (an antipsychotic medication) used to treat to treat schizophrenia and Tourette's Syndrome (disorder characterized by involuntary, repetitive movements or sounds called tics); and, Quetiapine fumarate (an antipsychotic medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorders (mental illnesses that are characterized by mood swings that range from the lows of depression to elevated periods of emotional highs)), with inadequate indications (a specific disease, condition, or symptom for which the drug is approved to be used to treat, prevent, or diagnose) for prescribing. This failure resulted in Resident 42 suffering from sedation (sleepiness caused by certain medications) and falls as well as the potential for suffering other adverse effects of antipsychotic medications such as abnormal involuntary movements and death. Finding: A review of Resident 2's admission record indicated was originally admitted to the facility on [DATE]. Resident 2 has a history of metabolic encephalopathy (a brain dysfunction caused by an underlying metabolic condition), unspecified dementia (loss of memory, language, problem-solving and other thinking) with behavioral disturbance, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). A review of Resident 2's Preadmission Screening and Resident Review (PASRR, a federally mandated nursing home screening assessment to ensure individuals with serious mental illness, intellectual disability, or related conditions receive the services they need in the most appropriate setting), dated 2/20/24, indicated Resident 2 had previously been prescribed .haloperidol lactate 5 mg [milligram, a unit of measurement]/ ml [milliliter, a unit of measurement]. injection inject 1 ml into the muscle every 6 hours as needed for agitation.[and] quetiapine 50 mg tablet take 1 tablet by mouth nightly. A review of Resident 2's Minimum Data Set (MDS-a resident assessment and classification tool), dated 8/26/24, indicated Resident 2 was taking antipsychotic, anti-anxiety, antidepressant, and anti-convulsant medications and an indication for these medications was noted. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a Brief Interview of Mental Status (BIMS, a cognitive screening tool used for all long-term care facilities) score of 3 which indicated severe cognition (the mental processes involved in thinking, learning, remembering, and understanding), exhibited delusions (misconceptions or beliefs that are firmly held despite reality), verbal and physical behaviors towards others (verbal outbursts and combativeness), and had anxiety and depression. A review of the PharmD Consult's Medication Regimen Review (MRR-a systematic and thorough evaluation of all the medicines a person is taking) for 6/27/25, the MRR indicated, The [Resident 2] has been prescribed Haloperidol 0.5 mg QHS [every night] for [stroke]. If an antipsychotic is necessary to treat delirium and agitation, Quetiapine and Risperidone [an antipsychotic] are considered safer alternatives. The [Resident 2] has an additional order for Quetiapine 50 mg QHS for [stroke] w/ [with] TBI. Physician/Prescriber Response. Disagree. Wrong indication for medication. During a concurrent observation and interview on 9/15/25 at 9:55 a.m. in Resident 2's room, Resident 2 was dressed in bed sleeping while Certified Nursing Assistant 7 (CNA 7) was sitting in a chair at the bedside. CNA 7 stated Resident 2 had a 24-hour one-to-one sitter (continuous supervision and assistance provided by one staff member to one patient who requires constant monitoring). CNA 7 stated Resident 2 will stay awake for a couple of nights and then sleep and does not get out of bed for two or three days. CNA 7 stated, We redirect her in the room. If she wants to go out of the room, we just follow her. We watch TV (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[television]together and sort through drawers to redirect. [Resident 2's] behaviors are monitored and managed by a 24-hour one to one sitter and medications.During a concurrent observation and interview on 9/16/25 at 8 a.m., Resident 2 was observed sleeping in bed. CNA 7 stated Resident 2 was asleep in bed at the start of the shift at 7 a.m. and the outgoing CNA informed her Resident 2 was in bed all night and slept well.During an observation on 9/16/25 at 12:04 p.m., Resident 2 was observed sleeping in bed.During an interview on 9/16/25 at 12:46 p.m. the Director of Nursing (DON) stated Resident 2 exhibited verbal and physical behaviors towards others and attempted to ambulate independently and was hard to redirect. The DON stated she was not aware Resident 2 had any hallucinations. The DON stated the black box warning (a warning placed on the labels of prescription medications to alert about serious risks) associated with the drugs for antipsychotics for elderly with dementia can be involuntary movements and an increased risk of death.During an interview on 9/16/25 at 3:42 p.m. the Consultant Pharmacist (PharmD Consult) stated the black box warning associated with quetiapine and haloperidol included cardiac problems, liver problems, and death. The PharmD Consult stated he had provided the facility warnings in his monthly medication reviews, but there was a lack of response as there were no changes in Resident 2's orders.During an interview on 9/17/25 at 8:05 a.m. the PharmD Consult stated the current indication for quetiapine, For [stroke] and TBI was inadequate. The PharmD Consult stated the current indication for haloperidol, for [stroke] with TIA was also inadequate.During an observation on 9/17/25 at 8:34 a.m. in Resident 2's room, Resident 2 was observed dressed and groomed, sitting in her wheelchair with breakfast in front of her on a bedside table. Resident 2 was observed to be falling asleep in the chair and not eating.During an observation on 9/17/25, at 11 a.m., Resident 2 was observed asleep in bed.During a concurrent observation and interview 9/17/25 at 3:31 p.m., Resident 2's Responsible Party (RP) was visiting. The RP stated, she has slowed down a lot since entering the facility, could be due to the medications. She has been sleeping more during past 6 months.A review of Resident 2's Order Summary Report for active orders as of 9/18/25, indicated physician's orders for: Haloperidol tablet 0.5 mg. Give 1 tablet by mouth at bedtime for stroke with Transient Ischemic Attack (TIA, a temporary interruption of blood flow to the brain that causes stroke-like symptoms) prescribed on 6/5/25; and, Quetiapine fumarate oral tablet 50 mg. Give 1 tablet by mouth at bedtime for stroke with Traumatic Brain Injury (TBI, a type of brain damage caused by an external force, such as a fall).During an interview on 9/18/2025 at 8:40 a.m. the Medical Director (MD) stated the indication for prescribing quetiapine fumarate, [stroke] and TBI and prescribing haloperidol, [stroke] and TIA were not proper indications. The MD further stated the black box warning for antipsychotics for the elderly include increased mortality and increased risk of falls. During an observation on 9/18/25 at 11:33 a.m. in Resident 2's room, Resident 2 was observed sleeping in bed.During a record review of the Mayo Clinic's Drugs and Supplements, a nationally recognized drug reference dated 9/1/25, indicated, Quetiapine. should not be used to treat behavioral problems in older adult patients who have dementia or Alzheimer disease.Haloperidol should not be used to treat behavioral problems in older patients who have dementia.[and] may cause some people to become dizzy, drowsy, or may cause trouble with thinking or controlling body movements .A review of the facility's Policy and Procedure (P&P) titled Behavior/Psychoactive Drug Management revised 1/24/24, indicated, Purpose.To provide a therapeutic environment that supports residents to obtain or maintain the highest physical, mental, and psychosocial well-being.		

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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 its policy and procedure for abuse for one resident (Resident 65) of 28 sampled residents when licensed nurses and the social service worker did not assess Resident 65 for emotional distress after Resident 65 reported an allegation of abuse. This failure decreased the facility's potential to ensure the safety and welfare of Resident 65 after an allegation of abuse was reported. Findings: A review of an admission record indicated Resident 65 was admitted to the facility in September 2023 with diagnoses which included heart failure, chronic respiratory failure, and muscle wasting and atrophy (muscle shrinking). In an interview on 9/15/25 at 9:54 a.m., Resident 65 stated a Certified Nursing Assistant 2 (CNA 2) was rough while providing her care the night before. Resident 65 stated CNA 2 made her feel afraid and added, If I was floating in my urine, I would not call him in [to help me]. Resident 65 further stated she reported the incident to CNA 3 this morning. In an interview on 9/15/25 at 4:37 p.m., Resident 65 reported she had asked CNA 2 to please be careful with her shoulders because she had chronic pain in them. Resident 65 stated CNA 2 proceeded to tell her she needed acupuncture and pushed his fingertips into her right shoulder. Resident 65 asked him to stop, and he did. Resident 65 then stated CNA 2 held her feet down while she tried to move herself up higher on the bed. Resident 65 told him to let go of her feet but did not understand why he would have done it at all. Resident 65 also stated CNA 2 leaned up against her so hard that it caused her so much pain that she screamed out. In an interview on 9/17/25 at 8:43 a.m., Resident 49 stated she remembered Resident 65 screaming, Ow, ow, ow. You're hurting me. Resident 49 stated she had been wearing ear plugs, and she heard Resident 65 scream very clearly. In an interview and concurrent record review on 9/17/25 at 3:59 p.m., Licensed Nurse 2 (LN 2) stated residents are expected to be monitored for sadness or pain every shift for 72 hours after an allegation of abuse. LN 2 reviewed Resident 65's progress notes dated 9/14/25 through 9/17/25 at 3:59 p.m. and acknowledged there were no progress notes that mentioned Resident 65 was involved in an allegation of abuse. LN 2 also acknowledged there were no care plans initiated between 9/14/25 and 9/17/25 at 3:59 p.m. regarding Resident 65's allegation of abuse. A review of the facility's policy and procedure 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.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 licensed nurses provided two residents (Resident 2 and Resident 74) of 28 sampled residents care that met professional standards of practice when neurological assessments were not completed per the facility's fall protocol after Resident 2 and Resident 74 had unwitnessed falls. These failures decreased the facility's potential to provide the expected nursing care indicated in resident care plans and accepted standards of practice. Findings: A review of Resident 2's admission record indicated admission to the facility on 2/20/24 with diagnoses which included metabolic encephalopathy (a change in the brain's function due to an underlying condition), dementia (a progressive state of decline in mental abilities), cerebral infarction (also known as a stroke, when blood flow to the brain is interrupted, which causes brain cells to die), and cognitive communication deficit (difficulty in communication caused by impaired brain function). A review of Resident 2's progress note dated 4/27/25 at 7:30 p.m. indicated, .Neuro checks stated d/t [due to] incident [fall] being unwitnessed. A review of Resident 2's Interdisciplinary Team (a group of professionals with different areas of expertise who collaborate to address a resident's care needs) progress note dated 4/28/25 at 9:07 a.m. indicated, .Current interventions. monitor for delayed injuries. Resident 2 was not sent to the hospital for further evaluation. A review of Resident 2's progress notes and neurological checks between 4/27/25 at 7:30 p.m. and 4/30/25 at 7:30 p.m. indicated neurological checks were not conducted per the facility's fall policy and procedure as there was no documented neurological check dated 4/27/25 at 9 p.m. or any neurological checks conducted after 3:39 a.m. on 4/28/25. A review of Resident 74's admission record indicated admission to the facility on [DATE] with diagnoses which included subdural hemorrhage (when blood pools between the brain and its outermost covering usually caused by a head injury), encephalopathy (a brain disease that alters brain function which can be caused by a stroke), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and cognitive communication deficit. A review of Resident 74's care plan regarding her risk for falls related to weakness, deconditioning, and confusion initiated on 5/22/25 indicated interventions which included, .Follow facility fall protocol. A review of a hospital computed tomography (CT, a medical imaging test that uses x-rays and computer technology to create detailed images of the body) scan of Resident 74's head dated 8/11/25 at 2:01 a.m. indicated, [Resident 74 had an] Unwitnessed fall. [There is a] Superficial [at the surface of the scalp] left frontal [front of head] cephalohematoma [a collection of blood between the skull and the membrane that covers the skull]. A review of Resident 74's SBAR [Situation, Background, Assessment, and Recommendation] Summary for Providers dated 8/11/25 at 2:59 a.m. indicated, .Nursing observations, evaluation, and recommendations are: Resident put on q [every] 1/2 hr [hour] neuro checks on returning to facility. Primary Care Provider responded with the following feedback. New Intervention Orders. Neuro checks [assessments] on returning to facility. A review of Resident 74's progress note dated 8/11/25 at 3:42 a.m. indicated, At [12:50 a.m.] CNA [Certified Nursing Assistant]. found [Resident 74] laying on her (R) [right] side on the floor next to her bed. On assessment resident was noted to have a hematoma [a localized collection of blood outside the blood vessels that causes swelling and bruising] forming on her forehead and a small laceration to her (r) elbow. Resident left facility by amb [ambulance] at 0200. A review of Resident 74's progress notes and neurological checks between 8/11/25 at 12:50 a.m. to 8/14/25 at 12:50 a.m. showed no documented neurological checks between 12:50 a.m. when Resident 74 was found on the floor and 2 a.m. when the ambulance picked up Resident 74 and brought her to the hospital. Furthermore, when Resident 74 returned to the facility from the hospital, there were no documented neurological checks conducted every half hour as directed by the physician. A review of Resident 74's care plan regarding her actual fall with injury on 8/11/25 indicated interventions which included, .Continue interventions on the (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at-risk plan.Monitor/document/report PRN [as needed] x [for] 72 h [hours] to MD [physician] for s/sx [signs and symptoms]: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation.A review of Resident 74's physician order summary conducted on 9/16/25 at 10:24 a.m. showed no active, discontinued, or completed physician's order to conduct neurological checks every half hour between 8/11/25 and 8/14/25.In an interview and concurrent record review on 9/17/25 at 12:10 p.m., Licensed Nurse 1 (LN 1) stated if a resident had an unwitnessed fall, then nurses are expected to conduct an assessment, take vital signs, complete neurological checks, and notify the physician, Director of Nursing, and the Administrator (ADM). LN 1 was not sure the frequency the neurological checks were supposed to be done but stated the computer charting would remind her. LN 1 conducted a record review of Resident 2's neurological checks dated 4/27/25 to 4/30/25. LN 1 confirmed Resident 2 only had neurological checks dated 4/27/25 and 4/28/25; Resident 2 did not have any neurological checks dated 4/29/25 or 4/30/25. LN 1 also conducted a record review of Resident 74 neurological checks dated 8/11/25 to 8/14/25. LN 1 confirmed Resident 74 only had neurological checks dated 8/11/25 and had two neurological checks dated 8/12/25.In an interview and concurrent record review on 9/17/25 at 3:59 p.m., LN 2 stated the purpose of neurological checks was to monitor the resident for delayed injuries. LN 2 also stated neurological checks were usually done for a total of 72 hours. LN 2 reviewed Resident 2's neurological checks dated 4/27/25 to 4/30/25 and confirmed Resident 2 did not have documented neurological checks conducted for a total of 72 hours. LN 2 also reviewed Resident 74's neurological checks dated 8/11/25 to 8/14/25 and confirmed Resident 74 did not have any neurological checks dated 8/13/25 or 8/14/25.In an interview on 9/17/25 at 4:21 p.m., the ADM stated she was aware neurological checks had not been completed as the nurse consultants had recently notified her.A review of the facility's policy and procedure titled Fall Management Program revised 11/7/16 indicated, Post-Fall Response.The Licensed Nurse will complete the.Neurological Flow Sheet for an un-witnessed fall, or witnessed fall with suspected or known head injury for seventy-two (72) hours following the fall incident. Perform neurological checks at the frequency ordered, or as the following to equal 72 hours.Every 15 minutes x 1 hour then; Every 30 minutes x 1 hour then; Every hour x 4 hours then; Every 4 hours x 66 hours or until the physician states it is no longer necessary or; after 72 hours if the resident's condition is stable and showing no signs or symptoms of neurological injury.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to recognize, report, and address the nutritive needs of one resident (Resident 62) of 28 sampled residents when Resident 62 lost 9.8 pounds between 8/6/25 and 9/5/25. This failure led to Resident 62 experiencing an unplanned weight loss without timely notification to the Director of Nursing, Physician, or Registered Dietitian per the facility's weight evaluation policy, thereby delaying necessary intervention. Findings: A review of Resident 62's admission record indicated admission to the facility on 6/6/25 with diagnosis including Discitis (an infection and swelling of the spongy, cushion-like disc between the bones in your spine [backbone]), Osteomyelitis (a bone infection caused by bacteria or other microorganisms), Congested Heart Failure (progressive condition where the heart muscle weakens and can no longer pump blood effectively), Type 2 Diabetes (high blood sugar), Hypothyroidism (a condition in which the thyroid gland does not produce enough hormones to regulate metabolism (how your body turns food and drink into energy) and physical growth and development), Moderate Protein Calorie Malnutrition (when an individual does not consume enough protein (an essential molecule in all living things) to meet their physiological needs), Gastro-Esophageal Reflux Disease (a condition in which stomach contents flows back into the food pipe), and Chronic Kidney Disease (a condition where the kidneys lose their ability to filter waste from blood). A review of Resident 62's care plan regarding her risk for altered endocrine status (the balance and function of the endocrine system which regulates metabolism and mood) related to her diagnosis of Type 2 Diabetes and Hypothyroidism, initiated on 6/12/25, indicated nursing staff were expected to: obtain a dietary consult for her nutritional regimen, and monitor, document, and report significant weight loss to the physician (MD) and dietician. A review of Resident 62's care plan regarding her risk for weight loss, initiated on 6/14/25, indicated nursing staff were expected to notify the MD and Registered Dietician (RD) of any significant change in Resident 62's weight. A review of an order summary report of Resident 62's active orders indicated, RD consult to evaluate and treat as needed. Order date 7/8/25. Resident 62's nutrition/dietary note dated 7/15/25 at 3:32 p.m. indicated the RD assessed Resident 62 due to a significant weight loss of 10.4 lbs between 6/25/25 and 7/3/25 which was related to a recent hospital visit. The RD also noted Resident 62's meal intake varied from 26 to 75%, she accepted evening snacks as observed by nursing staff, and she had an order to receive Glucerna(R) (a nutritional shake recommended for residents with diabetes). The RD recommended nursing staff to document the percentage of food Resident 62 ate, encourage Resident 62 to eat and drink, and for kitchen staff to offer Resident 62 as many of her preferred food as possible. The RD indicated she will continue to monitor Resident 62's nutritional parameters and will follow up on an as needed basis. A review of Resident 62's Interdisciplinary Team (IDT, a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a resident) progress note dated 7/17/25, indicated Resident 62 did not care for the facility's food and preferred to eat the food brought to her by her friends. The IDT note also indicated they were monitoring Resident 62's kidney function and would continue to monitor it. A review of Resident 62's weights and vitals summary indicated Resident 62 weighed: 169.8 lbs on 8/6/25 at 2:29 p.m. 160 lbs on 9/5/25 at 4:28 p.m. A warning note was triggered on 9/5/25 at 4:28 p.m. which notified staff that Resident 62 lost 9.8 lbs (a 5% change) compared to her weight of 169.8 lbs on 8/6/25. A review of a Minimum Data Set (MDS, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 9/8/25, indicated Resident 62: Had a Brief Interview of Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 12 meant Resident 62 was moderately cognitively impaired (a person may have some memory or orientation problems and might need assistance with daily tasks); Did not have poor appetite; Had impairment of both upper extremities (shoulder, elbow, wrist, hand); Required setup or clean-up assistance with eating; Was 59 inches tall and weighed 160 pounds (lbs); Had a weight loss (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 5 % or more in the last month or loss of 10% or more in the last 6 months; and, Was on a therapeutic diet (a specialized meal plan designed to manage specific health conditions or promote recovery);A review of Resident 62's medical chart between 9/5/25 to 9/14/25 showed no documented evidence of notification from licensed nursing staff or the MDS Coordinator (MDSC) to the Director of Nursing (DON), MD, or RD of Resident 62's weight loss of 9.8 lbs.A review of Resident 62's change in condition evaluation dated 9/16/25 at 4:54 p.m. indicated the MD was notified of Resident 62's weight loss on 9/16/25 at 5:15 p.m. which started on 9/5/25.A review of Resident 62's nutrition/dietary notes dated 9/5/25 to 9/15/25 showed no documented evidence of an assessment regarding a weight variance until 9/17/25 at 4:10 p.m.A review of Resident 62's nutrition/dietary note dated 9/17/25 at 4:10 p.m. indicated, Resident reports she is happy with her current weight. No specific weight goal in mind but would be ok with further weight losses.During an interview on 9/15/25 at 10:58 a.m., Resident 62 stated some of the food served was good and bad. Resident 62 stated the kitchen would run out of things. Resident 62 stated she received two snacks of cottage cheese, in the afternoon and evening, but the kitchen had not had cottage cheese for several days. Resident 62 stated there were no apples. Resident 62 stated last night her snack consisted of soda crackers. The kitchen ran out of everything last night.During an interview on 9/16/25 at 12:55 p.m., the Regional RD (RRD) a resident with a change in condition in weight should be placed on the weekly Weight Committee Meetings that took place on Thursdays. The RRD stated the RD conducted the resident's initial nutritional risk assessment and oversaw residents with weight loss.During an interview on 9/18/25 at 8:21 a.m., the RDD was asked why Resident 62's severe weight loss had not been addressed. The RRD stated Resident 62 had not triggered for weight loss in August, so Resident 62 had not been put back on the weekly Weight Variance meetings.During an interview on 9/18/25 at 8:55 a.m., Licensed Nurse 2 (LN 2) stated that when a resident had severe weight loss, the nurse would complete a change in condition evaluation. LN 2 further stated the nurse would investigate the reason for the weight loss and notify the resident's MD and the resident's responsible party. LN2 stated the nurse would also notify the RD who would make recommendations to the resident's MD.During an interview on 9/18/25 at 9 a.m., the MDS Coordinator (MDSC) stated weight loss should have been reported to the MD by the nurse as well as the resident's family if ok with resident and reported to the resident's Responsible Party (a person or entity who makes healthcare decisions for a resident who is no longer able to for themselves). The MDSC stated the MD would provide orders and the MD may say contact the RD for recommendations. The MDSC stated the resident's care plan should be updated accordingly.During an interview on 9/18/25 at 9:20 a.m., the DON stated Resident 62's MD should have been notified about the weight loss. The DON stated the Restorative Nursing Assistant (RNA, a nursing assistant with specialized training in rehabilitation skills who helps residents maintain and improve their functional abilities after an illness or injury) weighed the residents and the RNA should report the weight loss to the nurse who should have called the MD. The DON confirmed there were no nurse progress notes addressing Resident 62's latest severe weight loss. The DON stated Resident 62's weight loss was captured when she ran a weight report on 9/16/25 for residents' weights from 8/1/25 through 9/6/25.During an interview on 9/18/25 at 9:50 a.m., the RRD stated the RD ran the weight reports, which would have captured Resident 62's severe weight loss. The RRD stated the RNAs weighed the residents. The Regional RD Consultant stated if the resident had a significant change in their weight, the RNA should report to the nurse who would report to the resident's MD.During an interview on 9/18/25 at 10:25 a.m., the RRD stated the RD ran the weight report on 9/15/25, which was when the RD planned to run the weight report. The RRD stated the weight report did trigger a weight loss for Resident 62.During an interview on 9/18/25 at 4:17 p.m., the RD stated she relied on the Certified Dietary Manager (CDM) to meet the resident's nutritional needs because the CDM was present at the facility and she worked remotely from Bakersfield, CA. The RD stated she conducted nutritional risk assessments for residents upon initial admission and when a change of condition occurs. The RD stated she relied on the nurses to let her know if a resident had severe weight loss or changes in (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Fortuna Rehabilitation and Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 Newburg Road Fortuna, CA 95540	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional intake leading to weight loss. A review of the facility's policy and procedure titled Evaluation of Weight and Nutritional Status, revised 1/30/25, indicated, . Any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days, 10% in 180 days, or is considered insidious weight loss, will be evaluated by the IDT to determine the cause of weight loss/gain and the intervention(s) required.Once weight gain or loss as described above is identified, the IDT will.Identify and implement appropriate interventions.Update and revise the Care Plan, as appropriate.Notify the responsible party.Notify the Attending Physician.Notify the registered Dietitian.The resident's Attending Physician will be notified when there is a weight variance of 5 pounds in 1 month or a variance of 3 pounds in one month if the resident weighs 100 pounds or less.Such losses will be evaluated by the IDT to determine the cause and respond as appropriate.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure routine and emergency drugs were available for a census of 94 residents, when:1. Resident 73's routine buprenorphine - naloxone (a controlled substance used for chronic pain management) was unavailable for administration; and,2. The facility's oral and insulin emergency medication kits (e-kit) were not replaced within a timely manner.These failures decreased the facility's potential to meet residents' routine scheduled and emergency therapeutic needs.Findings:1. A review of Resident 73's admission Record indicated admission to the facility in June 2024 with diagnoses which included chronic pain syndrome and anxiety disorder (excessive worry, fear and nervousness that can interfere with daily life).A review of Resident 73's Order Summary Report (OSR, physician orders) dated 9/18/25, indicated an order to give one tablet of buprenorphine - naloxone 8-2 milligrams (mg, a unit of measurement) sublingually (under the tongue) four times a day (scheduled at 9 a.m., 12 p.m., 4 p.m. and 8 p.m.) for pain related to chronic pain syndrome, with a start date of 12/4/24.A review of Resident 73's Care Plan (CP, an individualized comprehensive plan for the resident's care and treatment) initiated on 7/3/24 indicated Resident 73 had chronic pain syndrome and to administer buprenorphine-naloxone per physician order.During an interview on 9/17/25 at 4:24 p.m. Licensed Nurse 5 (LN 5) stated Resident 73's routine scheduled dose of buprenorphine-naloxone was unavailable and Resident 73 had not received the 12 p.m. or 4 p.m. scheduled dose for that day. LN 5 stated Resident 73 had a physician's order to hold the buprenorphine-naloxone until the medication was available from the pharmacy. During a review of Resident 73's Medication Administration Record (MAR) on 9/18/25 at 8:37 a.m., the MAR for buprenorphine-naloxone on 9/17/25 indicated Resident 73 did not receive the 12 p.m., 4 p.m., and 8 p.m. scheduled doses. However, an additional entry on 9/17/25 indicated a one-time order was received on and administered on 9/17/25 at 8:11 p.m. for one tablet of buprenorphine-naloxone 8.2 mg.During a concurrent interview and record review on 9/18/25 at 1:14 p.m., the Director of Nursing (DON) reviewed Resident 73's MAR dated 9/17/25 for buprenorphine-naloxone. The DON acknowledged Resident 73 did not receive the buprenorphine-naloxone doses scheduled for 12 p.m. nor 4 p.m. on 9/17/25 because the medication was unavailable. The DON stated the expectation was for resident medications to be available for administration. The DON stated the licensed nurses assigned to administer medications should review and request a resident's medication be reordered prior to the last dose. During a telephone interview on 9/18/25 at 2:16 p.m., the Pharmacy Manager (PharmD M) stated the facility should check the resident's medication supply throughout the week and staff should request refills for scheduled controlled medication at least two to three days prior to the medication running out. During a telephone interview and record review on 9/18/25 at 2:53 p.m. with the Pharmacist (PharmD), Resident 73's order for buprenorphine-naloxone 8-2 mg was reviewed. The PharmD acknowledged resident medications should be available as ordered. The PharmD indicated the missed doses of buprenorphine-naloxone may cause Resident 73 to experience aches and pains and cause acute distress if Resident 73 continued to miss doses. The PharmD stated the facility needed to pay attention to the routine medications and request refills prior to the medication being unavailable. A review of the facility's policy and procedure (P&P) titled, Medication Administration revised in June 2025, the P&P indicated, All medications shall be administered according to physician orders, current best practices, and federal and state guidelines. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.2. During a concurrent observation and interview on 9/17/25 at 8:35 a.m. with the Infection Preventionist (IP) in Medication Storage room [ROOM NUMBER], an oral medication e-kit was observed sealed with a red tag. The IP stated the red tag indicated the e-kit had been opened and a form should be inside which included the following information: the date, time, the staff member who (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accessed the e-kit, the medication removed, and which resident received the medication. The oral medication e-kit was re-opened with the IP and the IP confirmed there was no documentation inside which indicated when the e-kit was last accessed or what medication was removed. During a concurrent observation and interview on 9/17/25 at 8:45 a.m. with the Director of Staff Development (DSD) in Medication Storage room [ROOM NUMBER], the insulin (a hormone that regulates blood sugar levels) e-kit was observed sealed with a red tag and a form titled, ER Box Medication Order Sheet was taped to the outside of the box. The DSD stated she had accessed the insulin e-kit on 8/8/25 at 11:30 p.m. for the identified resident, completed the attached form and taped it to the outside of the e-kit. The DSD acknowledged she did not know the process for the replacement of e-kits. During an interview on 9/18/25 at 10:57 a.m., the DON acknowledged e-kits should be replaced within 72 hours and staff were expected to call the pharmacy if the replacement had not been received after 72 hours. The DON acknowledged there should be documentation to indicate who opened the e-kit, what medication was taken and for which resident the medication was removed for. During a telephone interview on 9/18/25 at 2:16 p.m., the PharmD M stated the facility should complete a form that documented the date, time, medication, resident's name and the name of the licensed nurse who accessed the e-kit and then place a copy of the form inside the e-kit for the pharmacy to review. The PharmD M stated e-kits were replaced within 72 hours after being opened and confirmed the facility was responsible for notifying the pharmacy when an e-kit needed to be replaced. A review of the facility's P&P titled, Emergency Pharmacy Service and Emergency Kits revised January 2018, indicated, .The nurse records the medication use from the emergency kit on the [medication order/use form] and [calls the pharmacy for replacement of the kit/dose and/or flags the kit with a color-coded lock to indicate need for replacement of kit/dose] as soon as possible after the medication has been administered. Use of the emergency medication is noted on the resident medication administration record (MAR). Opened kits are replaced with sealed kits within [72 hours] of opening.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to provide nourishment that was palatable, textured, and attractive for one resident (Resident 58) of 25 sampled residents when a liquified pureed diet was provided contrary to the Responsible Party (RP, an individual or entity who has the primary duty to make healthcare decisions for a resident) and family preference and concern. This failure resulted in weight loss and a lack of dignity for Resident 58. Findings: A review of Resident 58's admission record indicated admission to the facility on 8/27/16 with diagnoses which included Alzheimer's disease (a progressive, irreversible brain disorder that causes memory loss, confusion, and other cognitive decline), type 2 diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), protein calorie malnutrition (a condition that occurs when a person does not consume enough protein and calories to meet their body's needs), and dysphagia, oropharyngeal phase (difficulty or inability to move food from the mouth through the throat (oropharynx) into the esophagus). A review of Resident 58's Care Plan dated 4/27/23 indicated staff were to, .modify diet as appropriate according to Resident's food tolerances and preferences. A review of Resident 58's Minimum Data Set (MDS-a standardized assessment tool) dated 6/19/25 indicated Resident 58 required complete assistance with eating and had no signs and symptoms of a possible swallowing disorder. A review of Resident 58's weight and vitals record dated 7/2/25, Resident 58 weighed 107.6 pounds (lbs.-a unit of measurement). A review of Resident 58's Speech Therapy Treatment Encounter Notes dated 7/2/25, indicated no contraindications was present for pureed texture foods. A review of Resident 58's Order Summary Report indicated an order dated 7/9/25, Pureed texture [food that has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding], Regular/Thin consistency [liquids], liquified pureed diet. A review of Resident 58's Dietary Progress Note dated 8/25/25 at 2:10 p.m. indicated Resident 58 was eating approximately 52% of meals. A review of Resident 58's weight and vitals record dated 9/5/25, Resident 58 weighed 102.6 lbs. During a concurrent observation and interview on 9/15/25 at 9:35 a.m. at Resident 58's bedside, Resident 58 was observed in bed with the head of bed elevated. A family member was at the bedside. Resident 58 appeared to have difficulty staying awake as the family member attempted to interact with the resident. The family member stated concerns about Resident 58's liquified diet and its nutritive value as it did not seem appetizing. The family member further expressed concern about Resident 58's weight loss. During an observation on 9/15/25 at 1:30 p.m. in Resident 58's room, Certified Nursing Assistant 5 (CNA 5) was observed feeding Resident 58. Resident 58 was in bed with the head of the bed elevated. Resident 58 was observed drinking through a straw from mugs held by CNA 5. There were four mugs on Resident 58's tray. The meal ticket on the tray indicated, Liquified food; cottage cheese, cheesecake, ice cream, pie cream, pudding, sherbet, soup cream, sour cream. thin liquids: milk 8 [ounces], water 8 [ounces]. A review of Resident 58's Order Summary Report printed 9/16/25, did not indicate any orders for vitamin and mineral supplements, fiber supplements, nutritional supplements, or for speech therapy evaluation and treatment. During an interview on 9/16/25 at 9:34 a.m. Resident 58's RP stated Resident 58's liquified diet was unappetizing and lacked dignity. During an interview on 9/16/25 at 12:46 p.m., the Director of Nursing (DON) stated, Not having dentures or teeth can affect all aspects of nutrition. The DON further stated a pureed texture diet would be more appetizing than a pureed liquid diet. During an interview with the Speech Therapist (ST) on 9/17/25 at 8:46 a.m., the ST stated a liquified pureed diet made it easy for Resident 58 to consume nutrition as the passage of food in the oral cavity was becoming more delayed. ST stated Resident 58 was previously on a pureed diet which was changed to a pureed liquid diet in July 2025 due to Resident 58's taking longer to move food around in his/her mouth when eating. The ST stated Resident 58 had never had a swallow study (a medical test that examines the process of swallowing) and was discharged from Speech Therapy (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services in July 2025. The ST stated a pureed texture was more appetizing and palatable than a liquified diet in her opinion. During an interview on 9/18/25 at 8:40 a.m., the Medical Director (MD) stated Resident 58 was on a liquified pureed diet. The MD stated a pureed texture was better than a liquified texture for maintaining eating and swallowing abilities. During an interview on 9/18/25 at 11:55 a.m., the Registered Dietician (RD) stated he first became aware of the liquified pureed diet about 5 months ago. The RD stated a pureed texture would be more appetizing than a liquified pureed diet. A review of the facility's Policy and Procedure (P&P) for Dysphagia Diets and Thickened Liquids, revised 1/1/12 indicated, Explain diet changes. And reasons for changes to the resident and/or responsible party.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review, the facility failed to ensure frozen vegetables stored in the freezer were sealed for 90 residents who received food from the facility's kitchen. This failure could cause frozen vegetables to develop freezer burn, which could negatively affect the quality of the vegetables by causing the vegetables to be dry, tough, and flavorless and had the potential to result in cross contamination leading to foodborne illnesses. Findings: During the initial tour of the kitchen on 9/15/25 at 8:50 a.m., three boxes of frozen vegetables carrots, green beans and corn were opened and not sealed in the walk-in freezer. The frozen vegetables that were opened were stored in their original blue plastic bags, which were open to air and placed back in their original cardboard boxes. The Certified Dietary Manager stated if frozen items are not sealed tightly, they could get freezer burn. During an interview on 9/16/25 at 12:30 p.m. the Regional Registered Dietician stated if a frozen vegetable was not sealed tightly, she would be concerned that something could spill inside the bag causing cross contamination more than freezer burn affecting the nutritional value. The facility Policy/Procedure titled, Food Storage and Handling, revised 2/29/24, indicated, .Frozen Meat, Poultry, and Food. Store items promptly at 0 F or below. Foods should be labeled, dated, and in their original containers if designed for freezing. Foods to be frozen should be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated papers.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record review, the facility failed to ensure resident safety for one resident (Resident 6) out of 25 sampled residents when the call light was out of reach. This failure decreased the facility's potential to ensure Resident 6's ability to notify staff if there was an emergency. Findings: A review of Resident 6's admission record indicated he was admitted to the facility in April 2022 with diagnoses which included cerebral infarction (when blood flow to the brain is interrupted causing tissue damage) and Post Traumatic Stress Disorder (PTSD, a mental health condition that develops after experiencing or witnessing a traumatic event). A review of Resident 6's Care Plan (CP, a comprehensive, individualized plan of care) indicated the following concerns and interventions: 1. Risk for falls: ensure the call light was within reach and needs prompt response to all requests for assistance, dated 9/8/22. 2. Impaired physical mobility and dependent on staff for care: ensure the call light is available, dated 4/23/24. During a concurrent observation and interview on 9/15/25 at 9:04 a.m. with Certified Nursing Assistant 5 (CNA 5), Resident 6's call light was observed on the floor, on the right side of the bed. CNA 5 acknowledged Resident 6's call light was on the floor and out of reach. CNA 5 acknowledged call lights should be placed within reach in case the resident needed to alert staff during an emergency or if the resident needed assistance. During a concurrent observation and interview on 9/17/25 at 10:56 a.m. with the Social Services Director (SSD), Resident 6's call light was observed on the floor, on the right side of the bed. The SSD acknowledged Resident 6's call light was on the floor and out of reach. The SSD stated, [Residents'] need the call light within reach so they can call for help. During an interview on 9/17/25 at 2:56 p.m. the Director of Nursing (DON) confirmed the call light should always be within reach of the resident. The DON stated, The call light needs to be within reach so residents can call for help or signal [staff] when they need assistance. A review of the facility's policy and procedure (P&P) titled, Communication - Call System revised January 2012, indicated, Call cords will be placed within the resident's reach.		