STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	04/12/2019

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37160 Based on interview and record review, the facility failed to ensure the accuracy of assessment for one of one resident reviewed for change of condition out of 17 sampled residents (Resident 35) when the Minimum Data Set (MDS-a resident assessment instruments-core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents) did not reflect Resident 35 was receiving hospice service(comfort care for terminally ill people). This failure resulted in three MDS with incorrect entries putting resident at risk for not receiving services. Findings: Review of the facility Matrix for Providers (used to identify pertinent care) received on 4/8/19, indicated the facility was providing hospice services for Resident 35. Review of the Minimum Data Sets dated 5/22/18 and 11/19/18 indicated Resident 35 was not receiving hospice service. The MDS dated [DATE] indicated Resident 35 was receiving hospice care. There was no MDS entry made for a Change of Condition. During an interview and concurrent record review on 4/11/19, at 11:41 p.m., Manager B stated MDS for Change of Condition is needed to be completed if a resident started receiving hospice service. Manager B verified Resident 35 did not have MDS for a Change of Condition. Manager B verified the MDS on 5/22/18, 8/22/18, and 11/19/18, did not indicate Resident 35 was receiving hospice service in the facility. Manage B stated Resident 35 was receiving hospice care since her admission on 5/18/18. At 11:53 a.m., Manager B verified the missed entries for Hospice service under Section O. Manager B stated, I will correct those (MDS entries). The facility provided a document titled CMS RAI Version 3.0 Manual (how to complete MDS) dated , d+[DATE], indicated the intent of Section O: Special Treatments, Procedures, and Programs was to identify any special treatments, procedures, and programs that the resident received during the specified time periods. Review of the CMS RAI Version 3.0 Manual dated 10/18, indicated, resident assessment process requires that the assessment accurately reflects the resident's status.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40254 Based on observation, interview and record review, the facility failed to individualize plans of care of 2 of 4 sampled Residents (Resident 58 and Resident 52) when: 1. The Careplan for Resident 58 failed to provide individualized interventions to reduce the risk of falls, which resulted in the Resident having five falls in a three-month period from 1/1/19 to 4/1/19, and resulted in multiple unwitnessed falls one with injury. (Cross Reference F689) 2. The Careplan for Resident 52, there was no care plan addressing non-compliance with repositioning before the pressure ulcer developed and the intervention for encouraging independent repositioning was not performed. (Cross Reference 686). This failure resulted in Resident 52 developing a Stage 2 pressure ulcer and at risk for developing another pressure ulcer. Findings: 1. During an interview with Resident 58 alone in her room on 04/09/19 at 3:55 p.m.: Have you had any falls? I did Can you tell me what happened? I don't remember During an interview with Unlicensed Staff Q on 04/10/19 at 08:24 a.m. she stated: I have worked here for one year, I am a traveler. I went into Resident 58's room and she was sitting on her bed crying, Resident 58 stated she had just fallen in the bathroom. I went to the nurse, told her, Licensed Nurse R went in to assess her and they sent Resident 58 out. Resident 58 has a bed alarm that she has had the whole time I've been here, because she has always been a fall risk. Resident 58 has a Tab alarm (The use of bed and chair alarms proliferated in the 1990s, when physical restraints were banned, and are intended to go off when a resident's weight shifts, indicating they may be trying to stand without assistance.) on wheelchair. Unlicensed Staff Q stated the hard part is Resident 58 is able to turn off her Tab alarm on the wheelchair. Resident 58 turns off her alarm and we repeatedly remind her to use her call-light, but she is non-compliant with that. Resident 58 gets upset when we try to help her. Her room has been by the nurses' station, her roommate is a fall risk also. Her roommate's alarm would go off and it would concern Resident 58. When her roommate gets agitated, we encourage Resident 58 to join us in the dining room for coffee so we can keep an eye on her. During interview on 04/10/19 at 11:04 a.m. with the Director of Nurses stated: Alarms, we continually remind Resident 58's call bell is in her reach, fall mat in place, every 2 hours, needs assistance, more often most of her falls are transferring from bed to wheelchair, wheelchair to bed, going to the bathroom by herself. Resident 58 never asks for assist. Resident 58 doesn't remember. Resident 58 came from a place in Fresno that was closed, mostly dementia, psych diagnoses. Resident 58 has a friend here, who came with her. Resident 58 has severe dementia. We have her as close to the nurses' station as we can, it's an all hands on deck. We had her on the RNA program for strength training and balance. We have done every 2 hours. But could not state when and documentation requested to support. She hasn't had any med changes. I would have to go back and look. She has a self-releasing seatbelt, we encourage her to go to the dining room for activities. During observation on 04/10/19 at 11:35 a.m. Resident 58 in bed in room, alone, no one in hallway. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 04/10/19 at 12:00 p.m. Resident 58 got up and wheeled out to dining room. No one assisted resident. When Resident got to dining room, a CNA asked if she needed assistance. Review of the facesheet (demographic data), indicated the facility admitted Resident 58 to the facility on [DATE] with primary diagnoses of Type 2 diabetes mellitus with diabetic neuropathy, unspecified Review of the Resident Admission assessment dated [DATE] indicated the Resident was alert, oriented to person, place, time. Resident was incontinent. Resident used a walker. Fall Risk Factors not checked on form, section left blank. Resident was independent with eating and bed mobility. Resident needed supervision with ambulating and transferring. Resident needed limited assistance with bathing, dressing, hygiene and toileting. Review of the Resident Care Plan Fall Risk Prevention & Management dated 10/18, with updates on 10/29/18, 11/16/18, 1/19,1/25/19, 2/5/19, 3/1/19 and 4/19 shows no mention of supervison of the Resident. The Care Plan indicates Resident is diagnosed with severe dementia. Resident forgets to use call light and wait for assistance. Resident at times will turn off bed alarm resulting in falls. Review of the Resident Care Plan Short Term related to Non Injury Falls dated 1/28/18, with updates 2/4/19, 2/11/19, 2/18/19, 3/4/19 The Care Plan indicates frequent checks, but does not specify how often Review of the Resident Care Plan Short Term related to Fall dated 1/1/19 with updates 2/1/18 and 2/8/18 with no new interventions post fall. Review of the Resident Care Plan Short Term related to Non Injury Fall dated 2/5/19 with updates 2/12/19, 2/19/19, 2/26/19, 3/5/19, 2/19/18, 2/26/19, 3/5/19 The Care Plan indicated frequent visual checks, but does not specify how often. Review of the Resident Care Plan Short Term related to Fall with injury dated 3/8/19, 3/15/19, 3/22/19, 3/29/19, 4/5/19, and 4/8/19 The Care Plan has no mention of supervison of the Resident. The Care Plan indicated continue to monitor closely while in room, but does not specify how often. 37160 2) Review of the Facesheet (demographic data) indicated the facility admitted Resident 52 to the facility on [DATE] with a primary diagnoses of Pneumonia (lung infection), malaise, diabetes mellitus (high blood sugar), and abnormalities with gait and mobility. Review of the Resident Baseline Evaluation dated 2/15/19, indicated Resident 52 had blanchable redness (skin loses redness with pressure. Non-blanchable is a stage 1 pressure ulcer, redness of intact skin ulcer in which skin does not lose redness with pressure) on her coccyx area. Review of the Short-term Non-Pressure Ulcer due to thin fragile skin dated 2/15/19, indicated for the staff to turn and reposition Resident 52 as scheduled; there was no defined timeframe for turning and repositioning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Skin Care Plan dated 2/19 indicated Resident 52 was at risk for skin breakdown/ulcer formation related to impaired mobility. The planned approach indicated to reposition Resident 52 during care rounds and encourage independent turning as applicable. Review of the Admission Minimum Data Set (MDS-a resident assessment instrument-core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents) dated 2/22/19 indicated Resident 52 needed an extensive assistance (resident involved in activity, staff provide weight-bearing support) from one person with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), toilet use, personal hygiene, and transfer (movement between surfaces including bed, chair, and standing position). Review of the Care Plan dated 3/27/19, indicated a problem Resident 52 was not compliant for side lying positioning, and a need for Alternating Pressure reducing overlay. During an interview and concurrent record review on 4/11/19, at 10:08 a.m., Licensed Nurse K stated Resident 52's Braden Scale score (tool used to predict pressure ulcer by assessing risk) on 2/15/19 was 12, which meant Resident 52 was at high risk for developing pressure ulcer. Licensed Nurse K stated Resident 52 was not compliant with repositioning. Licensed Nurse K verified the Care plan dated 2/19, indicated an intervention of repositioning and did not indicate a problem and intervention for Resident 52's non-compliance with repositioning. Licensed Nurse K reviewed and verified Nurse's progress notes did not have documentation related to Resident 52's noncompliance with repositioning until 3/27/19. Licensed Nurse K verified the care plan dated 3/27/19, indicated a problem of Resident 52's non-compliance (the same date the facility discovered the Stage 2 pressure ulcer). During an interview on 4/11/19, at 10:43 a.m., when asked regarding repositioning Resident 52, Unlicensed Staff N stated Resident 52 was on air mattress (alternating pressure reducing overlay) and no need to reposition her. Unlicensed Staff N stated Resident 52 rolls very well and no need to remind her to turn. The facility policy and procedure titled Comprehensive Person-Centered Care Planning dated 11/18, indicated, Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident . the comprehensive care plan will also be reviewed and revised at the following times: To address changes in behavior and care . 39792

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37160 Based on observation, interview, and record review, the facility failed to provide care to prevent pressure ulcer (a localized damage to the skin usually over a bony prominence or related to a medical or other device) from developing for 1 of three residents reviewed for pressure ulcer out of 17 sampled residents (Resident 52). This failure resulted to Resident 52 developing stage 2 pressure ulcer (sore digs deeper below the surface of your skin) on her coccyx (tailbone/buttocks region). Findings: Review of the Facesheet (demographic data) indicated the facility admitted Resident 52 to the facility on [DATE] with a primary diagnoses of Pneumonia (lung infection), malaise, diabetes mellitus (high blood sugar), and abnormalities with gait and mobility. Review of the Resident Baseline Evaluation dated 2/15/19, indicated Resident 52 had blanchable redness (skin loses redness with pressure. Non-blanchable is a stage 1 pressure ulcer, redness of intact skin ulcer in which skin does not lose redness with pressure) on her coccyx area. Review of the Short-term Non-Pressure Ulcer due to thin fragile skin dated 2/15/19, indicated for the staff to turn and reposition Resident 52 as scheduled; there was no defined timeframe for turning and repositioning. Review of the Skin Care Plan dated 2/19 indicated Resident 52 was at risk for skin breakdown/ulcer formation related to impaired mobility. The planned approach indicated to reposition Resident 52 during care rounds and encourage independent turning as applicable. Review of the Admission Minimum Data Set (MDS-a resident assessment instrument-core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents) dated 2/22/19 indicated Resident 52 had a Brief Interview for Mental Status (BIMS score- used to determine the resident's attention, orientation, and ability to register and recall new information) score of 8 out of 15 (scores of 8-12 moderately impaired cognition). The MDS indicated Resident 52 needed an extensive assistance (resident involved in activity, staff provide weight-bearing support) from one person with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), toilet use, personal hygiene, and transfer (movement between surfaces including bed, chair, and standing position). The MDS indicated Resident 52 was always incontinent when voiding and having bowel movements. The MDS indicated Resident 52 was at risk for developing pressure ulcers; Resident 52 did not have pressure ulcers. Review of the Physician Order dated 3/27/19, at 8:30 a.m., indicated for Alternating Pressure reducing overlay (placed on top of the bed) for skin integrity. At 2 p.m., there was an order for wound care of a Stage 2 pressure ulcer on the right buttock. Review of the Care Plan dated 3/27/19, indicated a problem Resident 52 was not compliant for side lying positioning, and a need for Alternating Pressure reducing overlay. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/08/19, at 12:23 p.m., Resident 52 was lying on her back in bed and denied having wounds During an interview on 4/09/19, at 9:30 a.m., Licensed Nurse K, stated Resident 52 had a facility-acquired (develop in the facility) pressure ulcer on her coccyx and it was resolved. During an observation on 4/09/19, at 10:15 a.m., Resident 52 was lying on her back in bed. During an observation on 4/09/19, at 1:01 p.m., Resident 52 was lying on her back in bed. During an interview and concurrent record review on 4/11/19, at 10:08 a.m., Licensed Nurse K stated Resident 52's Braden Scale score (tool used to predict pressure ulcer by assessing risk) on 2/15/19 was 12, , which meant Resident 52 was at high risk for developing pressure ulcer. Licensed Nurse K stated Resident 52 was not compliant with repositioning. Licensed Nurse K verified the care plan dated 2/19, indicated an intervention of repositioning and did not indicate a problem and intervention for Resident 52's non-compliance with repositioning. Licensed Nurse K reviewed and verified Nurse's progress notes did not have documentation related to Resident 52's noncompliance with repositioning until 3/27/19. Licensed Nurse K verified the care plan dated 3/27/19, indicated a problem of Resident 52's non-compliance; the same date the facility discovered the Stage 2 pressure ulcer. During an observation on 4/11/19, at 10:38 a.m., Resident 52 was lying on her back in bed. During an interview on 4/11/19, at 10:43 a.m., when asked regarding repositioning Resident 52, Unlicensed Staff N stated Resident 52 was on air mattress (alternating pressure reducing overlay) and no need to reposition her. Unlicensed Staff N stated Resident 52 rolls very well and no need to remind her to turn. The facility policy and procedure titled Pressure Injury Prevention dated 8/12/16, indicated, Non-compliance of the resident with the treatment plan (attempt to identify reasons for non-compliance when possible and develop alternatives) .Licensed Nurses will document effectiveness of pressure injury prevention techniques in the resident's medical record on a weekly basis.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40254 Based on observation, interview and record review, the facility failed to provide adequate supervision to reduce the risk of falls for one of four sampled residents at risk of falls (Resident 58). This failure likely contributed to Resident 58 having five falls in a three-month period from 1/1/2019 to 4/1/2019, which resulted in multiple unwitnessed falls, one with injury. Findings: During an interview with Resident 58 alone in her room on 04/09/19 at 3:55 p.m.: Have you had any falls? I did Can you tell me what happened? I don't remember During an interview with Unlicensed Staff P on 04/09/19 at 4:16 p.m. He confirmed he was working on 3/8/19, but stated he was not assigned to the Resident 58 when she fell . She has a self-release seatbelt, also a mat alarm on her wheelchair, a mat alarm in her bed, padded floor mat, room close to the nurses' station to hear the alarms. During a review of the clinical record for Resident 58, the annual MDS dated [DATE], Sections A, G, H and J indicated Resident 58 was independent with bed mobility, supervision with limited assistance with transfers, walking in room, locomotion off unit. ADL support provided. Resident 58 is not steady, but able to stabilize without staff assistance. Resident 58 using wheelchair. Resident is occasionally incontinent, Resident had two or more falls with no injury. During a review of the clinical record for Resident 58, the quarterly MDS dated [DATE], Sections A, G, H and J indicated Resident was limited assistance with bed mobility. Supervision and limited assistance with transfers. Limited assistance with walking in room. Limited assistance with toilet use. Resident 58 is not steady, but able to stabilize without staff assistance. Resident 58 uses a wheelchair. No urinary toileting program. Resident 58 is always continent. No bowel toileting program. Resident had two or more falls with no injury. Resident had one fall with injury. During a review of the clinical record for Resident 58, the significant change MDS dated [DATE], Sections A, C, G, H and J indicated Resident needs limited assistance with bed mobility and extensive assistance with transfers. Resident 58 needs extensive assistance walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing, toilet use, personal hygiene. Resident 58 is not steady, only able to stabilize with staff assistance. Resident uses walker and wheelchair. Resident is always continent. No toileting program. Resident had two or more falls with no injury. Resident had one fall with injury. Resident had one fall with major injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview with Unlicensed Staff Q on 04/10/19 at 08:24 a.m. she stated: I have worked here for one year, I am a traveler. I went into her room and Resident 58 was sitting on her bed crying, she said she had just fallen in the bathroom. I went to the nurse, told her, Licensed Nurse R went in to assess her and they sent Resident 58 out. Resident 58 has a bed alarm that she has had the whole time I've been here, because she has always been a fall risk. Resident 58 has a Tab alarm(The use of bed and chair alarms proliferated in the 1990s, when physical restraints were banned, and are intended to go off when a resident's weight shifts, indicating they may be trying to stand without assistance.) on wheelchair. The hard part is Resident 58 is able to turn off her Tab alarm on wheelchair. Resident 58 turns off her alarm, we repeatedly remind her to use her call-light, but she is non-compliant with that. Resident 58 gets upset when we try to help her. Resident 58's room has been by the nurses' station, her roommate is a fall risk also. Resident 58's roommate's alarm would go off and it would concern Resident 58. When her roommate gets agitated, we encourage Resident 58 to join us in the dining room for coffee so we can keep an eye on her. During an interview on 4/10/19 at 08:53 a.m. with Lisensed Nurse R. She confirmed she was the nurse for Resident 58 on 3/8/19. She stated that Resident 58 was up in wheelchair, she self transfered back into bed, we heard a noise and we ran in there. One of the CNA's found her and called me into the room. Resident 58 is so forgetful, she has been on bed and chair alarms for months/years. I asked her what were you doing? Resident 58 stated she was going to bed. Resident 58 is a quick little thing. Resident 58 was complaining of pain in her right hip. When I got in there, Resident 58 was sitting on the edge of the bed. The aide told me she had gotten up. Resident 58 has had so many falls. I called 911 and the MD. When Resident 58 came back later that day, we tried to keep her on bedrest using a bedpan, that didn't work because she kept getting up. Resident 58 had a bed alarm on. Resident 58 was a two person assist for a couple of days. We gave her multiple reminders, she couldn't remember. Then she was a one person assist, she had a self-releasing seatbelt, now she has a pull tab, she can turn it off. We run in there. We do walkby checks. During a review of the clinical record for Resident 58, the record indicated: Resident with multiple falls 3/8/2019, 2/4/2019, 1/25/2019, 1/18/2019, 1/1/2019. Resident with vascular dementia. During review of the clinical record for Resident 58, the Resident Admission assessment dated [DATE] indicates Resident is alert and oriented, incontinent and uses a walker. Resident needs supervision with ambulating and transfers. During review of the clinical record for Resident 58 for IDT notes dated: 3/8/19 fall, which indicated at 0615 resident was sitting on her bed and indicated she had fallen a few minutes prior. Transferred to Redwood Memorial Hospital for eval and treat. 2/5/19 fall, hx of falls. Resident was getting up from toilet and foot slipped. Resident fell backwards and hit head on sink. Nurse was present but unable to prevent fall. 1/28/2019 (fall 1/25/19) at 1350 Resident was standing up from wheelchair and lost balance and fell back and landed on her bottom and hit posterior head. 1/2/2019 Quarterly review: No mention of falls (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During review of the clinical record for Resident 58, the Post Fall Huddle dated11/15/18 indicated an unwitnessed fall on 11/15/18 at 0820 a.m. During review of the clinical record for Resident 58, the Therapy Post Fall Screen dated 1/1/19 indicated fall in room at 0700 a.m. During review of the clinical record for Resident 58, the Post Fall assessment dated [DATE] indicated no pain, no injury. During review of the clinical record for Resident 58, the Therapy Post Fall Screen dated 1/18/18 indicated fall in room at 1845 p.m. During review of the clinical record for Resident 58, the Post Fall assessment dated [DATE] indicated Resident had pain in her head 10/10, fall was unwitnessed During review of the clinical record for Resident 58, the Post Fall assessment dated [DATE] indicated Resident had pain posterior head 6/10, Resident found on floor. During review of the clinical record for Resident 58, the Therapy Post Fall Screen dated 1/25/19 indicated Resident had a fall in her room at 1350 p.m. Refer to RNA for strengthening. During review of the clinical record for Resident 58, the Post Fall assessment dated [DATE] indicated Resident had pain in the right occipital area During review of the clinical record for Resident 58, the Therapy Post Fall Screen dated 2/4/19 indicated Resident fell in bathroom at 0730 a.m. Currently on RNA program During review of the clinical record for Resident 58, the Post Fall assessment dated [DATE] indicated Resident had pain in Right Hip and Right Leg During review of the clinical record for Resident 58, the Therapy Post Fall Screen dated 3/8/19 indicated Resident fell in her room at 0615 a.m. Resident continues to self-transfer and not use call light. Resident with vascular dementia. During review of the clinical record for Resident 58, the SBAR Communication Form, dated 1/18/2019 indicates unwitnessed fall in bathroom on 01/18/19. During review of the clinical record for Resident 58, the SBAR Communication Form, dated 1/1/19 indicates fall, Resident turns off bed alarm During review of the clinical record for Resident 58, the SBAR Communication Form dated 2/4/19 indicates the Resident fell in the bathroom. During review of the clinical record for Resident 58, the SBAR Communication Form dated 3/8/19 indicates the Resident stated she had fallen, sent to Redwood Memorial Hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During review of the clinical record for Resident 58, the Nurses Notes, dated 1/28/19 night shift indicated s/p fall day 3 Neuro checks WNL. Resident continues to self-transfer despite numerous reminders to use call light and wait for assistance. During review of the clinical record for Resident 58, the Nurses Notes dated 2/4/19 at 2200 p.m. indicates witnessed fall this a.m. During review of the clinical record for Resident 58, the Nurses Notes dated 3/8/19 indicated Resident fell in her room. Resident sent to ER. Resident returned to facility with fractured hip. During review of the clinical record for Resident 58, the report from Redwood Memorial Imaging Ground level fall with right hip pain Impression: Moderately comminuted right greater trochanteric fracture. Dated 3/8/2019. During review of the clinical record for Resident 58, the Fall Risk Care Plan dated 3/19/2019. Dementia Care Plan dated 3/19/2019. MD order to start RNA program dated 1/21/19 for 3X week transfer training, ambulate with FWW. MD order ok to place seat belt alarm on wheelchair for increase safety measures. Understanding restraint use 12/1/14. informed consent 3/15/18 self-releasing seat belt in wheelchair. During interview on 04/10/19 at 11:04 a.m. with the Director of Nurses stated: Alarms, we continually remind her call bell is in her reach, fall mat in place, every 2 hours needs assistance, more often most of her falls are transferring from bed to wheelchair, wheelchair to bed, going to bathroom by herself. Resident 58 never asks for assist. She doesn't remember. Resident 58 came from a place in Fresno that was closed, mostly dementia, psych dx. Resident 58 has a friend here, who came with her. Resident 58 has severe dementia. We have her as close to the nurses' station as we can, it's an all hands on deck. We had her on the RNA program for strength training and balance. We have done every 2 hours. But could not state when and documentation requested to support. She hasn't had any med changes. I would have to go back and look. Resident 58 has a self-releasing seatbelt, we encourage her to go to the dining room for activities. During observation on 04/10/19 at 11:35 a.m. Resident 58 in bed in room, alone, no one in hallway. 04/10/19 at 12:00 p.m. Resident 58 got up and wheeled out to dining room. No one assisted resident. When Resident got to dining room, a CNA asked if she needed assistance.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39792 Based on observations, interview and record review, the facility failed to develop and implement new employee competency and ongoing competency assessment training program for Certified Nursing Assistants (CNAs). This failure had the potential for inappropriate and unsafe resident care resulting in potential injury or death. Findings: During a concurrent review of CNA Core Clinical Competencies and interview with Manager G on 4/9/19 at 2:43 p.m. indicated unlicensed staff had been deemed competent by the completion of the form. Manager G stated she used the form in documenting competencies with unlicensed staff members. Manager G indicated a check mark in the Yes column would signify the unlicensed staff member was competent to perform the task on residents. Manager G stated the form did not specify how the unlicensed staff member's clinical competency skills were assessed or measured, but she would ask the newly hired unlicensed staff member to verbalize how they would complete the task. Manager G indicated for instance under one of the competencies titled, Adult Brief Application the task had many steps involved and agreed to the difference between verbalizing how to complete the task and actually demonstrating competency by applying a brief to a resident. Manager G indicated if the newly hired unlicensed staff member could verbalize how to complete a resident care task, then the newly hired unlicensed staff would follow another CNA staff member around for a few days or however long it took for the CNA to demonstrate competency after performing the resident care tasks. Manager G could not explain how an unlicensed CNA staff member would indicate when the newly hired staff member was competent in performing a particular task since there was no documentation that was completed during this time period. Manager G stated it was a verbal agreement between each unlicensed staff member as to when the newly hired staff member was competent in performing resident care. Manager G stated the CNA Core Clinical Competency form did not include a signature of who assessed and deemed the newly hired staff member was competent and could not indicate how many times a newly hired staff member would perform a task appropriately to be deemed competent. Manager G indicated the variation of completing the resident care tasks were not evaluated during the new hire process meaning there was a lack in consistency between staff members in completing resident care tasks which exists amongst the CNA's. The facility did not produce a policy and procedure addressing competency assessment and resident care requirements.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37160 Based on observation, interview, and record review, the facility had a 7.14% medication error rate when two medication errors out of 28 opportunities were observed during medication passes for one of seven residents (Resident 215). These failures had the potential to compromise the residents' medical health. Findings: During a medication pass observation and concurrent interview for Resident 215 on 4/11/19, at 9:24 a.m., Licensed Nurse L prepared and verified four medications: Docusate sodium (stool softener), Clopidogrel (prevent blood clots) and Glimepiride and Metformin (both used to treat high blood sugar) for Resident 215. At 9:28 a.m., Resident 215 took all four medications. When asked what time Resident 215 ate breakfast, Resident 215 stated, just finish eating a while back. During an interview on 4/11/19, at 9:29 a.m., when asked how medications to be given with meals are given, Licensed Nurse L stated, I usually catch him (Resident 215) a little early in the morning. I try to get close as I can (administer medication at scheduled time). During medication reconciliation review on 4/11/19, at 9:36 a.m. for Resident 215. The Physician Discharge Summary with medication orders dated 4/2/19, indicated to give Resident 215 Metformin 1,000 mg by mouth, twice a day, with meals, and Atorvastatin Calcium (used to lower cholesterol level) 40mg by mouth, daily, at 9 a.m., which Licensed Nurse L did not give during medication pass observation. Review of the Medication Administration Records dated April 2019, indicated Metformin 1,000mg was scheduled to be given at 8 a.m. and 4:30 p.m., and Atorvastatin Calcium 40mg was scheduled to be given at 8 p.m. During an interview and record review on 4/11/19, at 3:42 p.m. License Nurse J verified the Physician Discharge Summary dated 4/2/19 was the Physician order for the medications. Licensed Nurse J verified the order for Atorvastatin Calcium 40mg, daily, at 9 a.m. Licensed Nurse J stated she scheduled the Atorvastatin at 8 p.m. instead of 9 a.m. as ordered was because Atorvastatin was supposed to be taken at night for best efficacy according to the Pharmacist. Licensed Nurse J stated she should have a clarification order regarding Atorvastatin administration time. The facility policy and procedure titled Medication Administration dated 1/12/12, indicated a Licensed Nurse will administer medication upon the order of a physician or licensed independent practitioner, one hour before or after the scheduled medication administration time; and the Licensed Nurse will keep in mind the seven rights of medication administration that included the right time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37160 Based on observation, interview, and record review, the facility failed to label drugs and biologicals in accordance with currently accepted professional principles when one of two vials of Tuberculin (used in skin test to aid diagnosis of tuberculosis (TB) infection in persons at increased risk of developing active disease.) did not have an opened date label. This failure had the potential for licensed nurse to administer expired drugs and biologicals to residents. Findings: During a medication storage observation and concurrent interview on 4/11/19 at 5:01 p.m., Licensed Nurse J verified the medication refrigerator contained one opened vial of Tuberculin with no opened date label. Review of the Tuberculin package insert (a document included in the package of a medication that provides information about that drug and its use.) taken out of the opened vial's packaging indicated, Vials in use for more than 30 days should be discarded. The facility policy and procedure titled Storage of Medication dated 2007, indicated Refrigerated medications are kept in closed and labeled containers .

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40090 Based on interview, and record review, the facility failed to provide necessary dental care for 6 residents (Resident 18, 29, 34, 52, 213 and 214) which had the potential to result in pain, impaired chewing capability, and further deterioration of oral health. Findings: During an interview with the Social Services Director (SSD), on 4/9/19, at 3:07 p.m., she described the process for dental services in the facility. The SSD stated Residents in need of dental services are transported to their personal dentist or a local dental clinic. The SSD stated that the facility had 2 vans with wheelchair lifts to transport residents to appointments. The SSD was unable to explain how residents that were not healthy enough to be transported were getting dental services. During an interview with the SSD, on 4/9/19, at 3:21 p.m., she stated that a mobile dental clinic provided services on 7/18 and was scheduled to return 5/19. The SSD explained how the facility ensured dental care was provided for newly admitted residents. The SSD stated the nurses evaluated residents at the time of admission and completed a dental assessment. The dental assessment would be reviewed within 24 hours during an interdisciplinary. The SSD stated that if a newly admitted resident's dental assessment required a dental appointment she would make arrangements for the resident to be seen either in the facility or at an outside resource. The SSD stated not one newly admitted resident had needed dental care that she was informed of since 7/18. 1. During a review of the clinical record for Resident 18, The Dental/Oral Assessment, dated 1/25/18 indicated Resident 18 required a referral to the dentist due to missing teeth. The assessment further indicated that the last exam was 3/28/18. The assessment was signed by licensed facility staff and dated 1/25/18. There were no other dental assessments in Resident 18's clinical record. During a review of the clinical record for Resident 18, The [sic] Dental Office Patient Notes, dated 3/28/18, indicated Resident 18 required full mouth debridement due to heavy plaque and calculus (Plaque is the sticky, colorless film that constantly forms on your teeth. Bacteria live in plaque and secrete acids that cause tooth decay and irritate gum tissue. If plaque is not removed regularly by tooth brushing and flossing, it hardens to create calculus, also known as tartar.) with moderately advanced periodontal condition (A bacterial infection that destroys the attachment fibers and supporting bones that hold the teeth in the mouth. Left untreated, periodontal disease can lead to tooth loss.) During an interview with the SSD, on 4/9/19, at 3:25 p.m., she confirmed that Resident 18 had not seen a dentist since 3/28/18. The SSD stated Resident 18 did not have an appointment with a dentist scheduled at the time of interview. 2. During a review of the clinical record for Resident 29, The Dental/Oral Assessment, dated 11/1/18 and reviewed 2/8/19, indicated Resident 29 required a referral to the dentist due to missing teeth. The assessment further indicated Resident 29 had not seen a dentist in the past year and an examination by a dentist should be performed. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/9/19, at 3:25 p.m., The SSD confirmed that Resident 29 had not seen a dentist since her admission to the facility on [DATE]. There was no upcoming appointment with a dentist scheduled at the time of interview. 3. During an interview with Resident 34 on 4/9/19 at 1:30 p.m., he indicated he had requested to have his upper and lower dentures fixed upon admission to the facility. Resident 34 stated he has not worn his dentures because they do not fit correctly. A review of Resident 34's Admission progress note on 4/10/19 at 4:13 p.m., indicated he was admitted to the facility on [DATE] with a history of a stroke (damage to brain due to interruption of blood supply to the brain), diabetes (a disease where the body is unable to process sugar in the blood appropriately) and generalized muscle weakness. During a review of Resident 34's Baseline Care Plan dated 1/22/19, indicated he had upper and lower dentures and the lower dentures were broken. During a review of Resident 34's Dental assessment dated [DATE] indicated his history of diabetes may effect his oral cavity, he had not been seen by a Dentist within the past year; therefore would need an examination by a Dentist. During a review of Resident 34's Social Services assessment dated [DATE] indicated he would be scheduled for a referral to a Dentist due to his dentures. During an interview with SSD on 4/10/19 at 5:18 p.m., she indicated Resident 34 had not been scheduled to be seen by a Dentist. SSD indicated she was not aware of Resident 34 having broken dentures and needing to be seen by a Dentist because she was not at the facility during the time of admission. SSD indicated she does not have a process to ensure residents who might have been admitted to the facility in need of dental services while she was away from the facility would not fall through the cracks so to speak. SSD indicated Resident 34 would be scheduled for a dental visit now that she was made aware of his need to see a Dentist. 4. During a review of the clinical record for Resident 52, The Dental/Oral Assessment, dated 2/15/19, indicated Resident 52 required a referral to the dentist due to missing teeth. The assessment further indicated Resident 52 had not seen a dentist in the past year and an examination by a dentist should be performed. During an interview, on 4/9/19, at 3:25 p.m., The SSD confirmed that Resident 52 had not seen a dentist since her admission to the facility on [DATE]. There was no upcoming appointment with a dentist scheduled at the time of interview. 5. During a review of the clinical record for Resident 213, The Dental/Oral Assessment, dated 3/20/19, indicated Resident 213 required a referral to the dentist due to broken teeth and missing teeth. The assessment further indicated Resident 213 had not seen a dentist in the past year and an examination by a dentist should be performed. During an interview with the SSD, on 4/9/19, at 3:25 p.m., The SSD confirmed that Resident 213 had not seen a dentist. The SSD restated that she had not been made aware any new admissions required dental referrals. There was no upcoming appointment with a dentist scheduled at the time of interview. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a review of the clinical record for Resident 214, The Dental/Oral Assessment, dated 4/1/19, indicated Resident 214 required a referral to the dentist due to broken teeth and missing teeth. During an interview, on 4/9/19, at 3:25 p.m., The SSD confirmed that Resident 214's dental needs were not addressed during the post admission review. The SSD confirmed that Resident 214 was admitted on [DATE]. The SSD requested time to follow up with Resident 214 and assist her with scheduling a dental appointment. The facility policy and procedure titled, Oral Healthcare & Dental Services, dated 7/14/17, indicated, under the Dental Assessments section, if a resident required specialized dental treatment, the resident's nurse is to notify the Attending Physician. The section further indicated the Physician would include an assessment of the resident's oral health status as a part of the initial medical assessment. The facility policy and procedure titled, Oral Healthcare & Dental Services, dated 7/14/17, indicated, under the Assisting Residents with Dental Appointments section, indicated The Social Services Staff was responsible for assisting with arranging necessary dental appointments. The section further indicated All requests for routine dental services should be directed to the Social Service Staff to ensure that appointments are made in a timely manner, and that Social Services would document extenuating circumstances that led to delayed referrals. 39792

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on interview and record review, the facility failed to ensure an effective Antibiotic Stewardship program was present and functioning, including promoting the appropriate use of antibiotics and consistent monitoring of antibiotic use to improve resident outcomes and reduction of antibiotic resistance, according to facility policy and procedure (P&P). This failure had the potential for inappropriate us of antibiotics resulting in adverse events associated with antibiotic use and subsequent antibiotic resistance (drugs designed to kill bacteria are no longer effective and bacteria are able to multiply). Findings: 1. During an interview and concurrent document review on 4/12/19 at 9:53 a.m., with Manager F, she indicated in the monthly Infection Control binder under January 2019, Resident 44 had been prescribed Levaquin for an upper respiratory infection as indicated by the physician order and monthly pharmacist review. The medication was indicated for treatment based on empirical (medical treatment based on experience or an educated guess in the absence of complete or perfect information). The pharmacy report indicated the medication was not selected according to the Antibiotic Stewardship policy and Manager G indicated she thought it was because the results of the chest x-ray were not included into the decision making process. Manager G indicated under the Respiratory Tract Infection Surveillance Data Collection form, the chest x -ray had been ordered by the physician as part of the decision making process, but there were no results documented in the medical record. Manager G indicated she was unclear if Resident 44 had the chest x-ray performed; which might be a reason why the results were not found in the medical record. During a review of Resident 44's clinical medical record on 4/9/19 at 1:16 p.m., indicated she was admitted to the facility on [DATE] with a history of chronic pain, atrial fibrillation (irregular, sometimes fast heart beat that commonly causes poor blood flow throughout the body) and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). A review of the clinical record for Resident 44 on 4/9/19 at 2:30 p.m. indicated on 1/29/19 the physician ordered Levaquin to be given by mouth every day for 5 days, (antibiotic medication commonly used for the treatment of pneumonia) and a chest x-ray. A review of the medical record indicated Resident 44 had a chronic cough and required the use of oxygen as an as needed basis due to low oxygenation levels obtained during vital signs. Physician orders dated 2/8/19 indicated Resident 44 was a severe carbondioxide retainer (C02, meaning the body is used to having higher level of carbon dioxide in the blood and when they are given too much oxygen the drive to breathe is diminished and they breath less or stop breathing all together creating a serious medical emergency). A review of the Medication Administration Review document on 4/11/19 at 5:30 p.m., indicated Resident 44 had her last dose of Levaquin on 2/7/19. 2. During a concurrent interview and record review with Manager G on 4/12/19 at 09:05 a.m., Antibiotic Utilization By Resident Report compiled during the monthly pharmacist review of antibiotics, indicated Resident 27 on 2/15/19 was prescribed Clotrimazole (anti-fungal oral medication used to treat an overgrowth of yeast in the mouth otherwise known as thrush). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's Admission record on 4/12/19 at 2:35 p.m.,indicated she was admitted to the facility on [DATE] with a history of difficulty in walking, major depression (mental health disorder characterized by loss of interest causing significant impairment in daily life activities) and glaucoma (a build up of pressure inside the eye resulting in blindness over time). 3. During a concurrent interview and record review with Manager G on 4/12/19 at 09:05 a.m., Antibiotic Utilization By Resident Report compiled during the monthly pharmacist review of antibiotics, indicated Resident 37 was residing in room [ROOM NUMBER] B and on 2/15/19 was prescribed Clotrimazole ((anti-fungal oral medication used to treat an overgrowth of yeast in the mouth otherwise known as thrush). Manager G was asked if there was a concern regarding two residents residing in the same room with the same diagnosis of Thrush and she stated neither resident had Thrush. Manager G stated after oral care had been completed and supervised by herself, the white patches (indications of fungal growth that cannot be wiped away during oral care) were no longer present. Manager G indicated the training with the Certified Nurse Assistants (CNAs) was completed at the bedside and no documentation was created to document the training that had taken place. Manager G indicated she did not think it was a wide spread educational need for all CNA's to be trained on appropriate oral care which would have removed the white patches from the mouth. The facility policy and procedure titled Infection Control, Policy for Antibiotic Stewardship Program, dated 1/2/18 indicated, An antibiotic review process, also known as antibiotic time-out for all antibiotics prescribed in the facility. iii. Whether appropriate tests such as cultures were obtained before ordering antibiotic .6. a. Infection Prevention and/or other members of the ASP team will review and report findings to facility staff and to Quality Assurance committee, who will then provide feedback .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 40090 Based on observation, interview, and record review, the facility failed to ensure 2 of 2 gas supplied cooking units, were maintained in working order which had the potential to cause property damage, injury or death. Findings: During an initial kitchen tour, on 4/8/19, at 8:29 a.m., observed a gas range and oven combination. Observed 8 cylindrical rods approximately one centimeter in diameter protruding from the front of the oven portion directly underneath the range. Noted a faint odor detected when approximately six inches away from the top of the range. Two pictures taken of the range and oven. At 8:32 a.m., Observed a range, grill top, oven combination. Observed white powdery substance on the burner of the range. Two pictures taken. No audible sound coming from the exhaust hoods above either range. During an interview with the Dietary Manager (DM), on 4/8/19, at 8:52 a.m., she stated the kitchen staff only use the oven portion of the range oven combination. The DM confirmed that the rods were where the knobs to turn the burners on the range would attach. The DM explained it was the older of the two cooking appliances, there were no knobs because they could accidently get turned on, releasing gas into the kitchen. The DM did not know who took the knobs off of the rods or when they were taken off. The DM stated that the rods could not be turned without the knobs. Observed rod turn to the on position with gentle pressure and no knob attached. The DM stated that the range was not being used, and confirmed that the facility does use the oven portion to cook meals and keep meals warm. During a concurrent observation, on 4/8/19, at 8:52 a.m., noted small particles of varying size with varying shades of white, yellow, and beige color splattered on range. Black and brown splatters on the backsplash of the unit. The substance was greasy and sticky to the touch. Upon further inspection of the top of the unit, observed multiple round red objects. During an interview, with the Dietary Manager (DM), on 4/8/19, at 8:58 a.m., she confirmed the red objects were the knobs for the range. when asked about the greasy and sticky substance on the backsplash, she stated she did not know how it got there. The DM stated that both units were cleaned by kitchen staff on a weekly basis. During an interview, with Cook Z, on 4/8/19, at 9:23 a.m., she confirmed the oven portion of the unit with missing knobs was being used on a weekly basis. When asked about the exposed rods, Cook Z did not know knobs were missing because the unit had been in that condition at the time of hire. During an interview, with the Maintenance Supervisor (MS), on 4/8/19, at 10:25 a.m., he stated he was unaware of any issue with the range oven combination unit in the kitchen. He confirmed there was no record of a service or maintenance request made prior to today for either of the two cooking units in the kitchen. When asked to describe the facility procedure processing a request, The MS stated all maintenance requests go directly to him for review, based nature of the request, the issue would be fixed by facility maintenance staff or a contracted repair company. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the DM, on 4/8/19, at 10:41 a.m., she stated she had worked at the facility for 9 years. The DM stated that the range and oven had been in the current condition since as long as she could remember. The DM had no service or maintenance records for either unit. The DM did not have the operation manual or service schedule for either unit. The DM stated that a contracted company provided cleaning and maintenance for both of the ventilation hoods located above both ranges. During an interview a service technician, on 4/10/19, at 11:15 a.m., he stated the 3 gas pilot lights were not lit, and prior to his adjustment the gas supply to the range was on. The technician explained that the combination of an open gas valve and clogged pilot stems could potentially allow for the burners to release gas into the kitchen without igniting it to flame. The technician used matches to light all the burners on the range, and was able to turn the rods to adjust the height of the flame without the knobs attached. Review of the [brand] Range and Oven manual, the installation instructions indicated the range had constant pilots (a small, continuously burning gas flame under a cooktop). Each pilot had a knurled nut with and adjusting screw. The manual directed owners to turn the adjusting screw until the pilot flame was 1/2 an inch high and then tighten the knurled nut to secure. The manual instructed owners to call their local gas company for minor adjustments. The manual, provided by the facility, referenced a separate instruction manual for service and maintenance instructions. On 4/10/19 at 3 p.m., requested the [brand] Range and Oven instruction manual, the facility could not produce the manual for review. A review of the [Appliance Store] Service Report, dated 08/17/17, indicated the [brand] Gas Range, Flat Grill and Oven unit was installed professionally and in good working order. A review of the [brand] Installation & Operation manual, page two indicated, WARNING Improper installation, adjustment, alteration, service or maintenance can cause property damage, injury or death. A review of the [brand] Installation & Operation manual for the range, grill, oven unit, under the maintenance and adjustments section, instructed owners to visit the brand's website for service and parts information. A review of the [brand] Installation & Operation manual for the range, grill, oven unit, under the troubleshooting section, instructed owners verify all parts are clean then call for service if the issue was related to range pilots and burners not lighting. During an interview, with The Administrator, on 4/11/19, at 9:51 a.m., he confirmed the facility had no record of service or maintenance being performed by an authorized service provider for either cooking unit. A review of the [brand] recommended service guidelines, indicated equipment must be maintained and serviced by trained maintenance person or an authorized service agency at regular intervals. Frequency of service was dependent on usage hours. For units that operate 10-12 hours a day 7 days a week, the recommendation was every 30-60 days. For units with limited daily usage, the recommendation was every 180 days. The guidelines further indicated that all units should be serviced at least once a year. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	04/12/2019

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure titled: Oven - Conventional (Gas) - Operation and Cleaning, dated 10/1/14, indicated dietary staff would operate equipment according to the manufacturer's guidelines. The operation procedure indicated that the oven should light automatically. 39792