STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poway Healthcare Center	15632 Pomerado Road Poway, CA 92064

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 1) was protected from abuse when Resident 1's wife was allowed to visit Resident 1 without close monitoring. This failure had the potential to affect Resident 1's safety and well-being. Findings:Resident 1 was admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition (inadequate intake of nutrients to meet the body's needs) and dementia (an impairment of brain function, such as memory loss and judgment) according to the facility's admission Record. A review of Resident 1's progress notes (PN) in the electronic medical record (EMR) was conducted. The PN dated 8/17/25 at 12:08 P.M. indicated Resident 1 reported to staff that his wife smacked him on his thighs.during assessment, resident told writer [Licensed Nurse 5] the spouse slapped him on the cheek. During an interview on 8/28/25 at 9:33 A.M. with the Administrator, the Administrator stated Resident 1's wife has been limited to visiting Resident 1 in the common areas for close monitoring of the resident. The Administrator stated Resident 1's wife was not allowed to visit Resident 1 in the room alone. An observation and interview with Resident 1 was conducted on 8/28/25 at 10:21 A.M. Resident 1 was lying in bed with oxygen on via nasal cannula (tubing through the nose). Resident 1 stated he just returned from therapy and his wife visited earlier. Resident 1 stated his wife has done unusual things in the past such as throwing a book at him while he and his wife were sitting around the dining table. Resident 1 stated there was some kind of altercation between him and his wife recently. Resident 1 stated he did not remember what happened, but something happened. Resident 1 stated he was unsure if it was safe to be with his wife but it was fine for her to visit. During an interview on 8/28/25 at 10:38 A.M. with Resident 1's assigned certified nurse assistant (CNA) 1, CNA 1 stated she was not aware of the abuse allegation involving Resident 1 and the wife. CNA 1 stated Resident 1's wife arrived around 9 A.M. and assisted Resident 1 with breakfast in Resident 1's room. CNA 1 stated Resident 1's wife was allowed to visit in the room without being closely monitored. An interview on 8/28/25 at 10:46 A.M. was conducted with licensed nurse (LN) 2. LN 2 stated she was aware of the allegation that Resident 1's wife smacked Resident 1. LN 2 stated the plan of care was to ensure Resident 1's safety and visitations should be in the common area only. LN 2 stated staff assigned to Resident 1 should be monitoring and should be aware of the incident. During an interview on 8/28/25 at 10:54 A.M. with CNA 2, CNA 2 stated Resident 1's wife used the microwave the day before on 8/27/25 then proceeded to go into Resident 1's room without being monitored. CNA 2 stated she was not aware that Resident 1's wife was not supposed to be in Resident 1's room alone. During an interview on 8/28/25 at 11:04 A.M. with LN 4 (Resident 1's assigned LN), LN 4 stated she did not receive report regarding Resident 1's abuse allegation and was not aware of the plan of care that Resident 1's visits with his wife should be monitored/ or that the visits should only be in the common area. An interview on 8/29/25 at 10:59 A.M. was conducted with the Director of Nursing (DON). The DON stated Resident 1's wife was allowed to visit Resident 1 in public areas such as the TV room or activity room, where the visits may be monitored, and not in Resident 1's room. The DON acknowledged that staff should monitor Resident 1 whenever his wife visits, to protect the resident from abuse. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022 was conducted. The P&P did not provide guidance for corrective actions when a family member was the alleged perpetrator. A review of the facility's policy and procedure (P&P) titled. Visitation, dated September 2022 was conducted. The P&P indicated, Some visitation may be subject to reasonable clinical and safety restrictions that protect the health, safety, security and/or rights of the facility's residents such as.denying access or providing limited and supervised access to an individual if that individual is suspected of abusing.a resident.