

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Villa Rancho Bernardo Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15720 Bernardo Center Drive San Diego, CA 92127	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint Numbers: The inspection was limited to the specific complaint and Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the complaint number: (Refer to Ftag F609). Findings:During a record review, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included hemiplegia and hemiparesis (paralysis affecting one side of the body) following cerebral infarction (a stroke) and unspecified dementia (a condition which affects memory, thinking, and the ability to perform daily activities).During a record review, the Minimum Data Set (MDS- a federally mandated assessment tool), indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition, or thinking skills) of 0 which indicated Resident 1 had severe cognitive impairment.During a joint observation and interview with Resident 1 on 2/26/26 at 9:27 A.M., Resident 1 was observed sitting in a wheelchair, in the dining room. There was a fading grayish green area of discoloration observed above Resident 1's right eyebrow. Resident 1 stated she did not remember how she sustained the discoloration above her eyebrow.During an interview with Resident 1's family member (FAM 1) on 2/26/26 at 10 A.M., FAM 1 stated he believed Resident 1 sustained the discoloration to the right eye because she fell out of bed during the night shift on 2/12/26-2/13/26. FAM 1 stated per the facility, there was no record of Resident 1 sustaining a fall. FAM 1 further stated the facility believed Resident 1 either bumped her eye on the bed's side rail, or accidentally hit herself with her hand. During a telephone interview with the Social Services Director (SSD) on 2/26/26 at 10:59 A.M., the SSD stated on 2/13/26, the facility was notified by Resident 1's family member (FAM 2) that there was discoloration on the right side of her eye. The SSD stated FAM 2 believed Resident 1 fell out of bed sometime during the NOC shift on 2/12/26-2/13/26, but the facility had no record of a fall. The SSD stated, [Resident 1] has vascular dementia that can wax and wane. When she first came in she was confused and barely able to answer questions. The SSD stated, [The Interdisciplinary Team- IDT- a group of professionals with different areas of expertise] had discussions that [Resident 1] could have bumped her head on the side rail, it's possible that she hit herself when removing her hand mittens. There's still a possibility that [Resident 1] could have fallen, we just don't know for sure. The SSD further stated on 2/16/26, while updating FAM 2 on the facility's investigation, [Resident 1's family] felt there was neglect.so that's when we reported it [to CDPH].During an interview with the Assistant Director of Nursing (ADON) on 2/26/26 at 2:43 P.M., the ADON stated we couldn't conclude the definite cause [of the injury] because it was not witnessed. We are looking at the possibilities. The ADON stated the facility determined Resident 1's injury was probably caused by either the side rail, or from Resident 1 accidentally hitting herself in the face. The ADON stated the facility had concluded the investigation into Resident 1's injury, and the facility was still not 100% certain of the cause. During an interview with the Director of Nursing (DON) on 3/4/26 at 3:07 P.M., the DON stated the facility concluded Resident 1 probably hit her head on the side-rail, or accidentally hit herself with her hand. The DON acknowledged Resident 1 could not (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>verify what happened, and there were no witnesses to verify how Resident 1 sustained the injury to the right side of her head. The DON acknowledged Resident 1's injury was unwitnessed and unexplained, but stated it was not reported to CDPH (California Department of Public Health) because she did not think it was reportable. During an interview with the Administrator (ADMIN) on 3/4/26 @ 3:07 P.M., the ADMIN acknowledged he was the facility's abuse coordinator. The ADMIN stated the facility did not consider Resident 1's injury reportable because, [the injury] was light in nature .During a review of the facility's policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revised 12/19/22, the policy indicated, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources. are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Injuries of unknown source: Includes circumstances when both the following conditions are met: i. The source of the injury was not observed by any person or could be explained by the resident. li. The injury is suspicious because of the extent of the injury, location of the injury. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after the discovery of the incident. During a record review, the facility's policy titled Abuse, Neglect, and Exploitation revised 12/19/22, the policy indicated, Reporting/Response.A. The facility will have written procedures that include. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. During a record review on 2/26/26, the facility's policy titled Unexplained Injuries, revised 12/19/22, indicated, Policy: All unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated. if the injury is of unknown source, reporting and investigating procedures shall be implemented in accordance with the facility's abuse policies and procedures.</p>		