STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Health and Rehabilitation Center	25924 Jackson Ave Murrieta, CA 92563

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on interview and record review, the facility failed to notify Resident 3 ' s Responsible Person (RP- person designated as being responsible for another person's medical and/or financial decisions) as well as other emergency contacts, of Resident 3 ' s change of condition (COC) and subsequent transfer to the general acute care hospital (GACH) on January 17, 2025. This resulted in the RP and emergency contacts being uninformed and unaware of Resident 3 ' s COC and transfer to the GACH. Findings: On January 29, 2025, at 9:37 a.m., Resident 3's RP was interviewed via telephone. The RP stated in the morning of January 17, 2025, family member (FM) 1 visited Resident 3 but did not stay long since Resident 3 had a cough. The RP stated in the afternoon of January 17, 2025, the facility called and notified her that Resident 3 ' s blood pressure (BP) was low and they were going to start intravenous (IV- into the vein) fluid hydration, and may possibly do an X-ray, after which the RP were to receive another update. The RP stated neither she nor her family members (FMs) received any notification from the facility thereafter. The RP stated the following morning (Saturday, January 18, 2025), FM 1 visited Resident 3 at the facility but did not find Resident 3 in the room. The RP stated FM 1 proceeded to the nurses ' station and asked where Resident 3 was, and was informed by the staff that Resident 3 was at the GACH, at a hospital where Resident 3 did not regularly receive prior care. The RP stated Resident 3 was transferred to the GACH due to low BP and low oxygen. The RP stated when they reached the GACH, Resident 3 was already admitted in the Intensive Care Unit, and was unable to communicate with them. The RP stated on Sunday, January 19, 2025, Resident 3 passed away. The RP stated she and the FMs felt they were robbed of precious time they could have spent with Resident 3, if they have been notified sooner of Resident 3 ' s change of condition and transfer to the GACH. A review of the facility ' s transfer and discharge list indicated Resident 3 was discharged from the facility on January 17, 2025. (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
	555915	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Health and Rehabilitation Center	25924 Jackson Ave Murrieta, CA 92563

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included acute congestive heart failure (heart muscle is weakened and cannot pump blood efficiently enough to meet the body's needs), atrial fibrillation (irregular heart rate and rhythm), and chronic kidney disease. A review of the facility document titled, SBAR (Situation, Background, Appearance Recommendation- a clinical assessment and communication tool): Change of Condition, dated January 17, 2025, 6:49 p.m., completed by Licensed Vocational Nurse (LVN) 1, indicated Resident 3 was sent out for hypoxia (low oxygen in the blood) and hypotension (low blood pressure), and that the RP was notified at 6:30 p.m. A review of the telephone order dated January 17, 2025, at 6:58 p.m., indicated, .Send out to (name of GACH) D/T (due to) Hypoxia and Hypotension . A review of the Progress Notes included a Family Update Note by the Director of Nursing (DON), indicating a call to the RP to .address the concern regarding the lack of family notification when the resident was transferred to the hospital on 1/17/25 at approximately 6:30 PM. (Name of RP) expressed that the family was very upset about not being informed promptly. Acknowledged her concerns and sincerely apologized, stating that there was no excuse for the communication lapse. (Name of RP) also informed (the facility [sic]) that the resident had passed away over the weekend, and staff offered deepest condolences for their loss . On January 29, 2025, at 3:59 p.m., during interview, the DON stated after investigating the incident, they found out three LVNs worked on sending Resident 3 out, and Resident 3 ' s charge nurse was LVN 1. LVN 1 assumed the other two nurses notified the RP and documented it as done, however; the RP and the FM were not notified of Resident 3's transfer to the GACH. The DON stated LVN 1 should have notified the RP and/or the emergency contacts himself, to make sure they were aware of what was happening with Resident 3. A review of the facility ' s policy and procedure titled, Notification of Changes, revised March 2023, indicated, .The facility informs the resident, the resident ' s physician, and the resident ' s representative when there is an accident resulting in injury, changes involving life threatening conditions .or transfer or discharge the resident .Guidelines: .The facility notifies .the resident representative of .A significant change in the resident ' s physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) .A decision to transfer or discharge the resident from the facility .Designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Health and Rehabilitation Center	25924 Jackson Ave Murrieta, CA 92563

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on interview and record review, the facility failed to accurately document the Responsible Person (RP) notification of one of three residents' (Resident 3) transfer to the general acute care hospital (GACH) on January 17, 2025. This failure resulted in inaccurate documentation of events in relation to Resident 3 ' s transfer process. Findings: On January 29, 2025, at 9:37 a.m., the RP was interviewed via telephone. The RP stated in the morning of January 17, 2025, family member (FM) 1 visited Resident 3 but did not stay long since Resident 3 had a cough. The RP stated in the afternoon of January 17, 2025, the facility called and notified her that Resident 3's blood pressure (BP) was low and that they were going to start intravenous (IV- into the vein) fluid hydration, and may possibly do an X-ray, after which they were to receive another update. The RP stated neither she nor her family members (FMs) received any notification from the facility thereafter. The RP stated the following morning (Saturday, January 18, 2025), FM 1 visited Resident 3 at the facility but did not find Resident 3 in the room. FM 1 proceeded to the nurses ' station and asked where Resident 3 was. After checking Resident 3 ' s record, the staff informed FM 1 that Resident 3 was at the GACH. The RP stated Resident 3 was transferred to the GACH due to low BP and low oxygen. The RP stated when they reached the GACH, Resident 3 was already admitted in the Intensive Care Unit, and was unable to communicate with them. The RP stated on Sunday, January 19, 2025, Resident 3 passed away. The RP stated she and the FMs felt they were robbed of precious time they could have spent with Resident 3, if they have been notified sooner of Resident 3 ' s change of condition and transfer to the GACH. A review of the facility ' s transfer and discharge list indicated Resident 3 was discharged from the facility on January 17, 2025. A review of Resident 3 ' s record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included acute congestive heart failure (heart muscle is weakened and cannot pump blood efficiently enough to meet the body's needs), atrial fibrillation (irregular heart rate and rhythm), and chronic kidney disease. A review the facility document titled, SBAR (Situation, Background, Appearance Recommendation- a clinical assessment and communication tool): Change of Condition, dated January 17, 2025, 6:49 p.m., completed by Licensed Vocational Nurse (LVN) 1, indicated Resident 3 was sent out for hypoxia (low oxygen in the blood) and hypotension (low blood pressure), and that the RP was notified at 6:30 p.m. A review of the telephone order dated January 17, 2025, at 6:58 p.m., indicated, .Send out to (name of GACH) D/T (due to) Hypoxia and Hypotension . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Health and Rehabilitation Center	25924 Jackson Ave Murrieta, CA 92563

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Progress Notes included a Family Update Note by the Director of Nursing (DON), indicating a call to the RP to .address the concern regarding the lack of family notification when the resident was transferred to the hospital on 1/17/25 at approximately 6:30 PM. (name of RP) expressed that the family was very upset about not being informed promptly. Acknowledged her concerns and sincerely apologized, stating that there was no excuse for the communication lapse. (name of RP) also informed that the resident had passed away over the weekend, and staff offered deepest condolences for their loss . On January 29, 2025, at 3:59 p.m., during interview, the DON stated after investigating the incident, they found out three LVNs worked on sending Resident 3 out, and Resident 3 ' s charge nurse was LVN 1. LVN 1 assumed the other two nurses notified the RP and documented it as done. However, the RP and the FM were not really informed of Resident 3's transfer to the GACH. The DON stated LVN 1 should have notified the RP and/or the emergency contacts himself, to make sure they were aware of the events.