STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555923	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temecula Healthcare Center	44280 Campanula Way Temecula, CA 92592

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39920 Based on observation, interview, and record review, the facility failed to provide adequate supervision for two residents reviewed for elopement (Resident 1 and Resident 2) when Resident 1 and Resident 2 had separate elopement (incident when a resident leaves the facility without authorization or supervision necessary for safety) episodes. This failure resulted in Resident 1 and Resident 2 being able to leave the facility undetected, which could have subsequently result in accidents, injuries, or even death to the residents. Findings: On March 28, 2024, at 9 a.m., an unannounced visit was conducted at the facility to investigate two incidents of elopement. On March 28, 2024, at 10:10 a.m., an observation and interview with Resident 1 was conducted. Resident 1 was alert and confused. Resident 1 was observed ambulating independently and stated she wanted to go home. Resident 1 did not remember the elopement incident. On March 28, 2024, at 12:26 p.m., an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated Resident 1 eloped on March 26, 2024, around 8 pm. Resident 1 was found outside the facility. RN 1 stated Resident 1 was an elopement risk because of confusion and wanted to leave the facility. RN 1 stated Resident 1 was not properly supervised to prevent elopement. On March 28, 2024, at 12:38 p.m., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 eloped on March 26, 2024, around 8 pm. CNA 1 stated Resident 1 had a Wanderguard (a personal alarm) on her left wrist because she was confused, was ambulatory and walked fast, independently. CNA 1 stated staff searched for Resident 1 inside and outside of the facility and did not find her. CNA 1 stated Resident 1 returned about 30 minutes later with a family member, in the family member's car. CNA 1 stated Resident 1 was not properly monitored and supervised to prevent elopement. Resident 1's record was reviewed. Resident 1 was admitted at the facility on March 20, 2024, with diagnoses which included cerebral infarction (lack of blood flow to the brain), and cognitive communication deficit. (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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's Elopement Risk assessment, effective date March 21, 2024, indicated: .Will not leave facility unattended .At risk for elopement . Resident 1's care plan, initiated March 24, 2024, indicated: .At episode of elopement r/t (related to) the following risk factors: expresses a desire to go home, history of elopement, resident representative voiced concerns resident may wander or attempt to leave facility .Goal . will not leave facility unattended . On March 28, 2024, at 11:57 a.m., an interview with RN 2 was conducted. RN 2 stated Resident 2 eloped on March 22, 2024, around 5 am, and was later found outside of the facility. RN 2 stated Resident 2 had a personal alarm on because she was an elopement risk due to confusion and elopement attempts. RN 2 stated Resident 2 was not properly supervised, and should have been supervised to prevent elopement. On March 28, 2024, at 1:08 p.m., an interview with CNA 2 was conducted. CNA 2 stated Resident 2 eloped on March 22, 2024, around 5 am. CNA 2 stated Resident 2 had a personal alarm on because she was an elopement risk. CNA 2 stated facility staff found Resident 2 outside of the facility and returned her to the facility. CNA 2 stated she was busy and was not able to respond to Resident 2's alarm on time. CNA 2 stated there was lack of supervision for Resident 2 in order to prevent elopement. On March 28, 2024, at 2:08 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 1 and Resident 2 elopement episodes were due to an issue of monitoring for safety. Resident 2's record was reviewed. Resident 1 was readmitted at the facility on March 20, 2024, with diagnoses which included psychosis (disconnection from reality), anxiety and depression. Resident 2's Elopement Risk assessment, effective date March 21, 2024, indicated: .Will not leave facility unattended .At risk for elopement . Resident 2's care plan, initiated March 21, 2024, indicated: .At episode of elopement r/t (related to) the following risk factors: cognitive deficits, expresses a desire to go home, history of elopement, resident representative voiced concerns resident may wander or attempt to leave facility .Goal . will not leave facility unattended . The facility policy and procedure titled, Wandering, Unsafe Resident, dated July 1, 2020, was reviewed. The policy indicated, .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement .The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, and monitoring as needed .