

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Temecula Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<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** 47202</p> <p>Based on interview and record review, the facility failed to report an allegation of physical abuse within two hours to the California Department of Public Health (CDPH) after the facility was made aware of the allegation, for one of four sampled residents (Resident 1).</p> <p>This failure had the potential to result in further abuse of Resident 1, affecting the resident's emotional and psychosocial well-being.</p> <p>Findings:</p> <p>On December 22, 2024 at 2:07 p.m., CDPH received a fax (facsimile - telephonic transmission of scanned-in printed material) report involving a complaint allegation of physical abuse for Resident 1.</p> <p>On December 2, 2024, at 9:31 a.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse.</p> <p>A review of Resident 1's Admission Record, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included Bipolar Disorder (a mental illness affecting mood and concentration).</p> <p>A review of Resident 1's Minimum data Set (an assessment tool) dated October 10, 2024, indicated a Brief Interview for Mental Status (used to identify the cognitive condition of a resident) score of 14 (cognitively intact).</p> <p>A review of Resident 1s eINTERACT Change in Condition Evaluation, dated November 21, 2024, indicated, . At around 4 p.m. CNA (Certified Nurse Assistant) reported patient refused to take a shower .patient complained of pain when she was brushing tangle hair .</p> <p>A review of Resident 1s SBAR Communication Form, dated November 22, 2024, indicated, . at approximately 0245 (2:45 a.m.) resident verbalized to staff that allegedly abused during PM shift .Resident stated alleged abuse occurred when staff attempted to shower her.</p> <p>A Review of Resident 1 Progress Notes, dated November 22, 2024 at 6:37 a.m., indicated .Called CDPH .in regards to allegation of abuse .</p> <p>(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>On December 2, 2024, at 10:05 a.m., during an interview with Resident 1, she stated on November 21, 2024 around 4:30 p.m., during her scheduled shower, CNA 1 brushed and pulled her hair hard. Resident 1 further stated she told CNA 1 she will not tolerate the abuse, and CNA 1 left the room afterward. Resident 1 stated she reported the incident to Licensed Vocational Nurse (LVN) 2, but LVN 2 did not do anything, so I reported to the night nurse.</p> <p>On December 2, 2024, at 10:30 a.m., during a concurrent interview and review of Resident 1 medical records with LVN 1, she stated all facility staff are mandated reporters and any allegation of abuse must be reported right away or within two hours to the CDPH, Ombudsman, police after the facility was made aware of the allegation. LVN 1 further stated on November 21, 2024 at around 4 p.m. CNA 1 reported to LVN 2 that Resident 1 complained of pain while her tangled hair was being brushed and alleged abuse. LVN 1 stated the incident was not reported to CDPH until November 22, 2024 at 6:37 a.m. (14 hours later). LVN 1 stated LVN 2 should have reported the abuse allegation incident to CDPH on November 21, 2024 to prevent further abuse.</p> <p>On December 2, 2024, at 11:45 a.m., during an interview with CNA 1, she stated on November 21, 2024 around 4:30 p.m., Resident 1 complained of pain and alleged abuse while she brushed and untangled Resident 1 hair during a scheduled shower. CNA 1 further stated she left Resident 1's room and reported the abuse allegation to LVN 2.</p> <p>On December 2, 2024, at 2:20 p.m., during a concurrent interview and review of Resident 1 medical records with the Assistant Director of Nursing (ADON), the ADON stated, any type of abuse or allegations of abuse should be reported to CDPH, ombudsman, police within two hours. The ADON further stated any allegation or suspicion of abuse should be reported to ensure the safety of the resident and prevent further abuse. The ADON stated on November 21, 2024 around 4:00-5:00 p.m., Resident 1 alleged abuse that CNA 1 pulled her hair too hard. The ADON further stated the abuse incident was not reported to CPDH until November 22, 2024 at 6:37 a.m. The ADON stated LVN 2 should have reported the abuse incident within two hours to CDPH on November 21, 2024.</p> <p>On December 3, 2024 at 1:53 p.m. during an interview with LVN 2, LVN 2 stated she was the nurse on duty when the incident occurred on November 21, 2024, around 4 p.m. LVN 2 stated CNA 1 came to her and informed her Resident 1 had alleged abuse while her hair was being brushed and untangled. LVN 2 stated she did not report the abuse allegation to CDPH and the incident was not reported until early morning on November 22, 2024. LVN 2 stated she should have reported the incident within 2 hours after being made aware of the allegation.</p> <p>A review of the facility policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, dated October 2022, indicated, . All reports of resident abuse .are reported to local, state, and federal agencies .Immediately .within two hours of an allegation involving abuse or result in serious bodily injury .</p>		