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	01/28/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44270 Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards was provided, when the bed alarm was not implemented for one of five residents reviewed for falls (Resident 1). In addition, Resident 1's fall risk assessment was not updated to reflect newly identified fall risks discussed during the interdisciplinary team (IDT - a group of healthcare professionals who work together for the common goal of the resident) meeting. These failures had the potential to result in further falls and injuries for Resident 1. Findings: On January 28, 2025, at 12:58 p.m. Resident 1 was observed to be sitting in a chair at the bedside. No bed alarm was observed on the bed or chair. A review of Resident 1's record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included repeated falls, unspecified dementia (memory loss). A review of Resident 1's Minimum Data Set, dated dated [DATE], indicated Resident 1's Brief Interview for Mental Status score was 7 (severely impaired cognitive status). A review of Resident 1's SBAR, (Situation-Background-Assessment-Recommendation- communication tool) dated January 18, 2025, indicated, .Patient (Resident 1) was found sitting on the floor beside her bed, when asked what happened patient stated that she was trying to take herself to the bathroom. When asked why she did not put on her call light, she said she thought she could do it by herself . A review of Resident 1's Care Plan initiated on January 18, 2025, with a revision on January 20, 2025, indicated, .Resident had an unwitnessed fall, was observed on the floor .review information related to the fall and conduct a root cause analysis to determine possible cause of fall. Alter/remove any potential causes if possible to determine new intervention .electronic alarm to (Specify: bed, wheelchair) .check functionality and placement every shift .alarm assessed as a possible restraint and does not prevent resident from rising . (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's IDT (Interdisciplinary Team - a group of healthcare professionals who work together for the common goal of the resident) Post Accident/Fall document, dated January 20, 2025, indicated, . Determined follow-up measures that are needed to reduce the risk of reoccurrence .bed alarm .updated post fall evaluation .new resident specific intervention initiated .bed alarm .updated post fall evaluation . Further review of Resident 1's medical record indicated there was no updated post fall evaluation for Resident 1. On January 28, 2025, at 1:13 p.m. an interview was conducted with the Certified Nursing Assistant (CNA). The CNA stated Resident 1 did not have a bed alarm in use and that she was not informed by nursing staff that a bed alarm should be in place for Resident 1. On January 28, 2025, at 2:12 p.m., a concurrent interview and record review were conducted with the Registered Nurse Supervisor (RN). The RN stated during the resident's IDT meeting, the team determined that Resident 1 should have a bed alarm and that an update to the post fall evaluation should be completed. The RN further stated Resident 1's care plan should have been implemented after January 20, 2025, as part of a fall prevention intervention. The RN stated, interventions outlined in care plans should be carried out and that post-fall interventions should be updated to reflect the current fall risks of residents at risk for falls. The RN stated, an update to Resident 1's fall risk assessment was not conducted. The RN also stated, the bed alarm should have been placed, and an updated fall prevention evaluation should have been completed to mitigate further fall risks for Resident 1. On January 28, 2025, at 3:33 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1 had one fall in the facility and that during the IDT meeting on January 20, 2025, it was determined that Resident 1 would benefit from having a bed alarm and that an updated post fall evaluation should be conducted. The DON stated a few days after the meeting, the care team determined that Resident 1 no longer needed the bed alarm and that the care plan should have been updated to reflect this change. The DON stated it was facility policy to update the fall evaluation after a resident experiences a fall to determine current fall risks and needs. The DON stated an updated post-fall evaluation was not conducted for Resident 1 and stated that it should have been completed to provide the most up-to-date and accurate assessment of fall risks, ensuring appropriate interventions to prevent further falls. The facility policy and procedure titled, Safety and Supervision of Residents, dated 2001, indicated, . individualized, resident-centered approach to safety .the interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents .the care team shall target interventions to reduce individual risks .implementing interventions to reduce accident risks and hazards shall including the following .communicating specific interventions to all relevant staff .assigning responsibility for carrying out interventions .ensuring that interventions are implemented; and documenting interventions .falls . The facility policy and procedure titled, Falls-Clinical Protocol, dated 2001, indicated, .the staff .will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable .the staff .will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling .