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	03/03/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review the facility failed to provide access to personal and medical records within two working days upon request by the resident's legal representative, for one of three sampled residents (Resident 1). This failure has the potential to delay care and treatment, affecting the resident's physical well-being. Findings: On March 3, 2025, at 9:05 a.m., an unannounced visit to the facility was conducted to investigate a resident's rights issue. A review of Resident 1's Admission Record, indicated, Resident 1 was admitted to the facility on [DATE], and was discharged from the facility on January 29, 2025. A review of Resident 1's Release of Medical Information, request, dated February 11, 2025, indicated, . (name) requester .Please consider this as (Resident 1 name) request, by and through this office as legal representative, that all writings related to her within your care, custody and control .that be made available within two working days from the receipt of this correspondence . On February 3, 2025 at 1:02 p.m., during a concurrent interview and review of Resident 1's release of medical information request form with the Medical Records Director (MRD), she stated the process for handling requests for a resident's medical records from a law firm, requires such request to be sent to the facility's legal team. The MRD stated, the facility's legal team either releases the records to the requester or provides approval before any records are released. The MRD further stated the records would be released to the requester within the time specified by the requester or within 15 days, in accordance with facility policy. The MDR stated on February 11, 2025, at 1:08 p.m., she received the request and forwarded it to the facility's legal team, requesting Resident 1's medical records be released to Resident 1's legal representative within two working days. (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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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MRD stated on February 14, 2025, at 12:15 p.m., Resident 1's legal representative contacted the facility to follow up on Resident 1's medical records request. The MRD further stated she contacted the facility's legal team who requested additional records for review. The MRD stated she did not provide an update to the legal representative and had not followed up with the legal team since February 14, 2025. The MRD stated Resident 1's medical records had not been released to the requester. The MRD stated Resident 1's medical records should have been provided within two working days as specified by the requester or within 15 days, in accordance with the facility policy. On February 3, 2025 at 2 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated, medical records could be requested by residents, their representatives or legal representative, and should be provided within two days after the facility received the request. During a review of the facility policy and procedure titled, Resident/Personal Representative Access To Protected Health Information, dated June 2016, indicated, .The facility shall allow an adult resident or his/her personal representative to .receive copies of his/her protected health information (PHI) in a designated record set with an oral or written requests .The requested PHI shall be provided timely .discharged Residents: Within 15 calendar days after the receipt of written request .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review the facility failed to ensure for one of three sampled residents (Resident 2) had a physician order prior to hospital transfer. This failure had the potential to affect Resident 2's overall health and wellbeing. Findings: On March 3, 2025, at 9:05 a.m., an unannounced visit to the facility was conducted to investigate a complaint incident. A review of Resident 2's Admission Record, indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included atrial flutter (an abnormal heart rhythm that can cause an individual to faint). A review of Resident 2's Health Status Note, dated February 19, 2025, indicated, .Was helping patient to use the bathroom, while sitting on toilet patient was straining and eyes rolled back and proceeded to pass out .AMR (American Medical Response) was called and arrived on scene where he (Resident 2) was then transported to (name of hospital) for further assessments . A review of Resident 2's SNF/NF to Hospital Transfer Form, dated February 19, 2025, indicated, .Sent to (name of hospital) .Date of transfer: 2/19/2025 17:50 (5:50 p.m.) .Reason for Transfer: Unresponsive . Further review of Resident 2's medical records, indicated Resident 2 was transferred to the hospital without a physician order. On March 3, 2025, at 9:50 a.m., during a concurrent interview and review of Resident 2's Health Status Note with Registered Nurse (RN) 1, he stated the process when a resident has a change in condition includes notifying the physician and obtaining a transfer order prior to hospital transfer. RN 1 stated, on February 19, 2025, Resident 2 was transferred to the hospital without a physician's order. RN 1 stated an order should have been in place prior to Resident 2 transfer to the hospital. On March 3, 2025, at 2 p.m., during a concurrent interview and review of Resident 2's Health Status Note with the Assistant Director of Nursing (ADON), the ADON stated prior to a hospital transfer, the physician should be notified, and an order must be in place. The ADON stated, Resident 2 was transferred on February 19, 2025, without a physician's order. The ADON stated, an order is essential to ensure resident safety and appropriateness of the transfer. A review of the facility policy and procedure titled, Change in a Resident's Condition or Status, dated 2001, indicated, .The nurse will notify the resident's attending physician or physician on call when there has been a .need to transfer the resident to a hospital/treatment center .discharge without proper medical authority .

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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** 47202 Based on interview and record review, the facility failed to ensure medical records were accurate for one of three sampled residents (Resident 2) when the time of the alleged abused was not consistent with the time of reporting. This failure resulted in inconsistencies in the reporting timeline for Resident 2. Findings: On March 3, 2025, at 9:05 a.m., an unannounced visit to the facility was conducted to investigate an allegation of financial abuse. A review of Resident 2's Admission Record, indicated, Resident 2 was admitted to the facility on [DATE]. A review of Resident 2's Minimum Data set (MDS - an assessment tool), dated August 12, 2024, indicated Resident 2 had a Brief Interview for Mental Status (tool used to assess a resident's cognitive function) score of 11 (moderate cognitive impairment). A review of Resident 2's eINTERACT SBAR Summary for Providers, dated February 18, 2025, at 7:49 a.m., indicated, .Alleged financial abuse against pt's (patient's) wife . A review of Resident 2's IDT (Interdisciplinary team) Note, dated February 18, 2025, at 6:22 p.m., indicated, . Alleged financial abuse by wife . Facility was made aware of alleged abuse today .Ombudsman, CDPH (California Department of Public Health) and Police have been contacted . On March 3, 2025, at 11:20 a.m., during a concurrent interview and review of Resident 2's eINTERACT SBAR Summary for Providers note with the Social Service Director (SSD), she stated, on February 18, 2025, Resident 2 alleged his wife was using his bank account and a large sum of money was missing. The SSD further stated Resident 2's daughter informed the Case Manager (CM) of the allegation on February 18, 2025, around 2 p.m. and the allegation did not happen at 7:49 a.m. The SSD stated she did not know why the nurse documented the incident time as 7:49 a.m. On March 3, 2025, at 12:21 p.m., during a concurrent interview and review of Resident 2's eINTERACT SBAR Summary for Providers note with Registered Nurse (RN) 2, she stated, she was the nurse who created and documented the note. RN 2 further stated she was not at work when Resident 2 alleged financial abuse on February 18, 2025, and she did not know what time the abuse incident occurred. RN 2 stated when she came to work on February 19, 2025, the Director of Nursing (DON) asked her to create a late entry note for Resident 2's abuse allegation incident and she just followed what the DON said. RN 2 stated she should not have documented on Resident 2's medical records because she was not at work when the abuse allegation happened, and it created confusion and inaccuracy on Resident 2's medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 3, 2025, at 12:51 p.m., during an interview with the CM, she stated on February 18, 2025, at 2 p.m. , Resident 2's daughter reached out to her and alleged Resident 2's wife used his money without Resident 2's approval. On March 3, 2025, at 2:43 p.m., during an interview with the DON, he stated on February 18, 2025, at 2 p.m. , Resident 2's daughter had alleged financial abuse by Resident 2's wife. The DON stated, on February 19, 2025, he had asked RN 2 to create a late entry documenting Resident 2's abuse allegation, but RN 2 had forgotten to adjust the time of the incident. The DON stated, RN 2 had not been working at the facility on February 18, 2025, and should not have documented in Resident 2's medical records. The DON stated, it's my mistake, and he should not have asked RN 2 to document the incident and should have written it himself. The DON further stated, it created confusion and inaccuracy of Resident 2 medical records. The DON stated the facility did not have a specific policy related to late charting, but it was standard of practice for staff not to document in a resident's medical record if staff was not scheduled to work. A review of the facility policy and procedure titled, Charting and Documentation, dated 2001, indicated .All services provided to the resident .Or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .Documentation in the medical record will be objective, complete and accurate .