

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 04/30/2025
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** Based on interview, and record review, the facility failed to ensure an injury of unknown origin involving one of five residents, (Resident 2) was reported to the State Survey Agency, (SSA), within two hours. Resident 2 was found by staff on April 22, 2025, visibly distressed, and verbally expressing severe pain with a bleeding wound on the right posterior scalp, which the resident could not explain the cause.</p> <p>This failure had the potential for a delay in the SSA investigation, which could result in missed opportunities for safety improvement and implementation of corrective actions.</p> <p>Findings:</p> <p>On April 22, 2025, at 4:38 p.m., the state survey agency received a call from the facility ' s Director of Nursing (DON), to report Resident 2 ' s injury of unknown origin that occurred on April 22, 2025, at approximately 3 a.m.</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted on [DATE], with diagnoses of displaced (the bone fragments are not properly aligned) intertrochanteric fracture of left femur (a break in the upper part of the thigh bone), aneurysm of artery (a bulge or ballooning in the wall of a blood vessel) of lower extremity, and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). Further review of the record indicated Resident 2 was transferred to the general acute care hospital (GACH) on April 22, 2025.</p> <p>A review of Resident 2 ' s History and Physical dated March 17, 2025, indicated no focal deficits (problem with nerve, spinal cord, or brain function).</p> <p>On April 24, 2025, at 1:50 p.m., during an interview with the Licensed Vocational Nurse (LVN), the LVN stated that on April 22, 2025, at approximately 3 a.m., Resident 2 was found in her room with blood dripping from her head. The LVN stated they were unable to determine what had happened and Resident 2 was unable to verbalize what had happened. The LVN stated that they should report an injury of unknown origin to the DON or the Administrator right away.</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 April 24, 2025, at 3:36 p.m., during an interview, the Assistant Director of Nursing (ADON) stated Resident 2 had an injury of unknown origin that happened on April 22, 2025, at 3 a.m. The ADON stated that the facility is required to report injuries of unknown origin within two hours to the SSA, the Ombudsman, and law enforcement. The ADON stated the facility reported Resident 2 ' s injury of unknown origin after twelve hours.</p> <p>On April 24, 2025, at 5:06 p.m., during a telephone interview, the Certified Nursing Assistant (CNA) stated she was caring for Resident 2 on April 22, 2025. The CNA stated on April 22, 2025, at 2:52 a.m., as she was walking by Resident 2 ' s room, she observed Resident 2 thru the open door, leaning over her over-bed table. The CNA stated she noticed the resident ' s walker was turned over on the side, and there was a large pool of blood in the middle of the floor. The CNA stated she called for assistance, and the facility called 911; and transferred Resident 2 to the hospital.</p> <p>A review of Resident 2 ' s eINTERACT SBAR, dated April 22, 2025, at 3:31 a.m., indicated .Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Bleeding (other than GI) . Nursing observations, evaluation, and recommendations are: Patient (sic) was observed standing in her room, using her bedside table for support, and repeatedly yelling to call her (family member). Blood was noted on the floor, as well as on the patient ' s jacket (sic) and the right posterior side of her head. Upon assessment, a wound was identified on the right posterior scalp. The patient was visibly distressed, verbally expressing severe pain and yelling. She complained of an intense headache. When asked why and how she started bleeding patient is unable to recall. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Transfer to acute hospital for further eval due to bleeding from the back of head .</p> <p>A review of Resident 2 ' s Progress Notes, dated April 22, 2025, at 8:24 a.m., indicated Late Entry: Writer called and faxed SOC 341 to CDPH and Ombudsman Office. (Name of City) Police was notified (sic) .</p> <p>A review of Resident 2 ' s Progress Notes, dated April 22, 2025, at 12:52 p.m., indicated Late Entry . resident was last seen by the CNA at around 1:40 am on 4/22/25 and observed to be asleep in bed. CNA stated: Throughout the night, I checked on the patient three times prior to the incident&mdash;each time to assist with her bedpan. On all three occasions, she appeared to be in a deep sleep and required waking to respond. The first time I had checked her was about 11:30 pm, while the last time I had went into her room (before the fall) was around 1:30/1:40 am before I went to my lunch. Shortly after returning from my lunch break around 2:52 am, I was walking past her room when I noticed the patient had just opened the door, same time as I was walking by. I found the patient (sic) hunched over her bedside table (at around 2:52 am). I immediately observed her walker knocked over on the floor, a significant amount blood in the middle of room on the ground, and bleeding from a head wound. I tried asking her what had happened but did not get a response until the nurse came in who speaks the same language as her. I quickly approached to support her and called out for the nurse on duty. We promptly assisted her back to bed, notified the RN supervisor, and contacted emergency services (911). During this time, the patient appeared confused, repeatedly asked for her son, and expressed head pain. LVN stated: Upon assessment, the patient was noted to have an open wound on the right side of the back of her head. When asked if she had fallen, (sic) the patient stated, I don't know what happened to me, and was unable to recall the event .</p> <p>(continued on next page)</p>		

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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>A review of Resident 2 ' s Hospital History and Physical, dated April 22, 2025, at 6:05 p.m. indicated .Patient was found to have trace pneumocephalus, (the presence of air or gas within the skull), SAH, (subarachnoid hemorrhage - bleeding in the area between the brain and the thin tissues that cover and protect it), and SDH, (subdural hematoma - a collection of blood that forms between the brain and the inner layer of the protective tissue surrounding the brain), and will be admitted to ICU (Intensive Care Unit), for further monitoring with trauma team as primary.</p> <p>A review of the facility ' s policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised October 2022, indicated . Reporting Allegations to the Administrator and Authorities . If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 2. The administrator and/or designee or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <ol style="list-style-type: none"> a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. <p>3. Immediately is defined as:</p> <ol style="list-style-type: none"> a. within two hours of an allegation involving abuse or result in serious bodily injury . 		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to ensure a copy of the discharge notice was sent to the Long-Term Care (LTC) Ombudsman at the same time the notice was provided to one of four sampled residents (Resident 1).</p> <p>This failure had the potential for the LTC Ombudsman not to be able to advocate for the resident in protecting their rights from inappropriate transfer and discharge.</p> <p>Findings:</p> <p>On April 30, 2025, at 9:14 a.m., an unannounced visit to the facility was initiated to investigate an admission, transfer, and discharge rights concern.</p> <p>A review of Resident 1 ' s History and Physical, dated April 3, 2025, indicated Resident 1 was alert and oriented to person, place, and time.</p> <p>On April 30, 2025, at 10:29 a.m., during an interview, the Social Services Designee (SSD 1) stated that the discharge notice for Resident 1 should be sent to the LTC Ombudsman office at the same time the discharge notice is sent to the resident or the resident representative, which should have been on April 22, 2025, for Resident 1.</p> <p>On April 30, 2025, at 10:54 a.m., an interview was conducted with SSD 2. SSD 2 stated that the discharge notice for Resident 1 was provided to Resident 1 ' s family member over the phone and a copy was provided to Resident 1, on April 22, 2025. SSD 2 stated that they sent the discharge notice to LTC Ombudsman on April 25, 2025, by fax.</p> <p>A review of Resident 1 ' s Notice of Transfer / Discharge, issued on April 22, 2025, indicated .Notification Date: 4/22/25 .Effective Date:: 4/25/25 .This notice to inform you that transfer/discharge is necessary for the following reasons .The transfer or discharge is appropriate because your health has improved sufficiently so you no longer require services by this facility .Copy of State LTC Ombudsman Office date: 4/25/25 .</p> <p>A review of Resident 1 ' s Progress Notes, dated April 25, 2025, at 3 p.m., indicated .Patient with an order to Discharge to home . Patient left the facility at around 3 pm pickup by [name of transportation company] .</p> <p>A review of the facility policy and procedure titled Transfer or Discharge Notices, revised March 2025, indicated .Notice of Transfer or Discharge (Anticipated) . 4. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative .</p>		