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 03/05/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an alleged incident of physical abuse involving two of seven residents reviewed (Resident 1 and Resident 2), was reported to the state survey agency (SSA) within two hours of the incident. On January 4, 2026, Resident 1 was observed pushing Resident 2, who subsequently claimed to have been choked by Resident 1. The alleged physical abuse occurred on January 4, 2026, at 6:30 p.m., and was not reported to the SSA until 9:15 a.m., on January 5, 2026.This failure had the potential for further abuse and a delay in the investigation of the event.Findings:On January 27, 2026, at 11:22 a.m., an unannounced visit to the facility was conducted to investigate allegations of abuse. A review of Resident 1's (alleged perpetrator) admission record indicated the resident was admitted on [DATE], with diagnoses which included peripheral vascular disease (PVD - condition in which arteries outside the heart become narrowed or blocked), anxiety disorder, (a chronic condition characterized by an excessive and persistent sense of apprehension), right below the knee amputation (BKA), Diabetes Mellitus type 2 (a chronic condition that affects the way the body uses sugar. The body either resists the effects of insulin - a hormone that regulates the movement of sugar into the cells - or doesn't produce enough insulin to maintain normal sugar levels), encounter for orthopedic aftercare following surgical amputation, acquired absence of other left toe(s), acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection), left ankle and foot, cellulitis (infection of the skin and the tissues beneath the skin), of left lower limb, and methicillin resistant staphylococcus aureus infection (MRSA - a bacteria with antibiotic resistance).A review of Resident 1's History and Physical, dated January 1, 2026, indicated resident had no neuro focal deficits, (Speech, vision, and hearing problems).A record review of Resident 1's eINTERACT SBAR (Situation, Background, Appearance, Review) Summary for Providers, dated January 4, 2026, at 5:41 p.m. indicated .Nursing observations, evaluation, and recommendations are: Writer was notified of an incident that occurred at around 18:30 at hallway of Station 3. Writer promptly interviewed al (sic) parties involved. [Resident 2] reported that he encountered LVN [name of Licensed Vocational Nurse 2] and admitted to using profanity towards the LVN [LVN 2] related to an incident on [DATE]. [Resident 1] witnessed the verbal altercation between LVN [name of LVN 2] and [Resident 2] and intervened.A record review of Resident 1's Progress Notes, dated January 4, 2026, at 7:15 p.m., indicated, [Resident 1] stated that [Resident 2] came very close to his face, prompting him to push [Resident 2] away.A review of Resident 2's (alleged victim) admission record indicated resident was admitted on [DATE], and discharged on January 15, 2026, with diagnoses which included opioid use, anxiety disorder, displaced (the bone fragments are separated or misaligned), bicondylar fracture of left tibia (severe, high-energy injury where the upper part of the left shin bone is broken into two or more pieces, involving both the inner and outer sides), subsequent encounter for closed fracture with routine healing status post open reduction and internal fixation (ORIF - a surgical procedure to fix broken bones by realigning the fragments and holding them together with hardware like plates, screws, or rods), and pedestrian on foot injured in collision with car, pick-up truck or van in nontraffic accident, (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: 555923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subsequent encounter.A review of Resident 2's History and Physical, dated January 5, 2026, indicated resident was oriented to person, place, and time.A review of Resident 2's Progress Notes, dated January 4, 2026, at 5:50 p.m., indicated, [Resident 2] stated, He [referring to Resident 1] choked me, but I managed to get out. LVN [name of LVN 2] stated that he intervened to separate two patients in order to prevent further escalation. treatment staff assessed [Resident 2] for skin issues or injuries; refer to skin assessment notes. MD was notified and ordered a psychiatric evaluation and monitoring for emotional distress. Writer also notified the patient's [family member] of the incident. Writer and Social Services interviewed [Resident 1], denied choking [Resident 2]. [Resident 2] came very close to his [Resident 1] face, prompting him to push [Resident 2] away.A record review of Resident 2's eINTERACT SBAR Summary for Providers, dated January 4, 2026, at 7:48 p.m., indicated, .Writer was notified of an incident that occurred around 18:30. I promptly interviewed all parties involved. [Resident 2] reported that he had an encounter with LVN [name of LVN 2] and admitted to using profanity toward the LVN [name of LVN 2] related to an incident on Jan. 3, 2026. Another patient [Resident 1] witnessed the verbal altercation between LVN [name of LVN 2] and patient [Resident 2] and intervened.On January 27, 2026, at 2:42 p.m., an interview was conducted with LVN 1. LVN 1 stated that when two residents have a physical altercation the Registered Nurse should be notified immediately. LVN 1 confirmed that physical altercations should be reported within two hours of the event.On January 27, 2026, at 2:57 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated that the physical altercation between Resident 1 and Resident 2 occurred on January 4, 2026, at 6:30 p.m. The SSD confirmed that the SSA was notified on January 5, 2026, at 9:15 a.m.On January 27, 2026, at 3:02 p.m., an interview was conducted with Resident 1. Resident 1 stated that he observed that Resident 2 was trying to tell a lie about LVN 2 on January 4, 2026, unable to recall the time. Resident 1 stated that he was standing up for LVN 2, and he (Resident 1) denied that LVN 2 had asked for Resident 1's assistance. Resident 1 stated that Resident 2 got into his face, so he pushed Resident 2 away from him. Resident 1 denied that he choked Resident 2.On January 27, 2026, at 3:43 p.m., an interview was conducted with LVN 2. LVN 2 stated that Resident 2 was up on crutches out in the hallway and started verbally yelling at him (LVN 2). LVN 2 stated that Resident 1 came out of his room and approached Resident 2 who got very close to Resident 1's face, and Resident 1 pushed Resident 2 away.On January 27, 2026, at 4:29 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that the altercation between Resident 1 and Resident 2 occurred on January 4, 2026, at 6:30 p.m. The DON stated that the incident was reported to the SSA on January 5, 2026, at 9:15 a.m. The DON confirmed that the altercation which is considered abuse and should have been reported to the SSA immediately and was not.On March 2, 2026, at 2:59 p.m., a telephone interview was conducted with the DON. The DON confirmed that the altercation between Resident 1 and Resident 2 on January 4, 2026, was reported to the SSA due to physical abuse.A review of the facility's policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, indicated, .1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. 3. Immediately'' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.

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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** Based on interview and record review, the facility failed to ensure for one of seven residents (Resident 3), that the correct laboratory test was carried out and completed. The physician ordered a stool culture for C-diff (a highly sensitive, specialized laboratory test used to detect the presence of Clostridioides difficile bacteria in feces, usually in patients with persistent, antibiotic diarrhea); however the facility carried out a stool culture (a laboratory test that detects disease-causing bacteria, viruses, or fungi in a stool sample to diagnose infections causing diarrhea, fever, or abdominal pain). This failure had resulted in undiagnosed and untreated underlying cause of diarrhea leading to Resident 3 to continuously experience diarrhea until December 31, 2025. This ongoing condition substantially contributed to an elevated white blood cells (WBC-essential immune system cells produced in the bone marrow that protect the body against infections, viruses, and foreign invaders) count of 36.91(normal reference range 4.0 to 11.0). The resident was subsequently transferred to the general acute care hospital (GACH) on January 1, 2026, at 2:12 a.m., and later passed away. Findings: On January 27, 2026, at 11:22 a.m., an unannounced visit was conducted at the facility to investigate quality care issues.A review of Resident 3's admission Record indicated resident was admitted on [DATE], with diagnoses of encounter for surgical aftercare following surgery on the digestive system, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disease (a mental health condition that causes extreme mood swings that include emotional highs and lows). A review of Resident 3's History and Physical, dated December 22, 2025, indicated resident had no neuro focal deficits (speech, vision, and hearing problems).A review of Resident 3's Physician Orders for Life -Sustaining Treatment (POLST), dated December 19, 2025, indicated, .Comfort-Focused Treatment .Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction .Request transfer to hospital only if comfort needs cannot be met in current location .A review of Resident 3's SBAR Situation Background Appearance Review Communication Form, dated December 25, 2025, indicated, .The change in condition, symptoms, or signs observed and evaluated is/are: Diarrhea This started on 12/25/2025.Recommendations of Primary Clinicians (if any): stool culture for C-diff. A review of Resident 3's Order Summary, dated December 25, 2025, at 9:35 p.m., indicated, CULTURE, STOOL ** SENT .A review of the Order Summary dated December 25, 2025, and the SBAR dated December 25, 2025, indicated the laboratory test carried out for Resident 3 was stool culture and not the laboratory test ordered by the physician as indicated in the SBAR which was stool culture for C-diff.A review of Resident 3's Bowel Continence/Movements, indicated the following:December 26, 2025, at 4:17 a.m., indicated 1, (incontinent) 4, (large), 4, (loose). December 26, 2025, at 5:25 p.m., indicated 1, (incontinent), 3 (medium), 5, (watery).December 27, 2025, at 7:03 p.m., indicated 1, (incontinent), 4, (large), 5, (watery). December 28, 2025, at 7:33 a.m., indicated 0, (continent), 4, (large), 5, (watery).December 29, 2025, at 6:29 a.m., indicated 0, (continent), 3, (medium), 4, (loose). December 29, 2025, at 10:54 a.m., indicated 0, (continent), 4, (large), 4, (loose).December 29, 2025, at 6:04 p.m., indicated 0, (continent), 2, (small), 5, (watery). December 30, 2025, at 6:49 a.m., indicated 1, (incontinent), 3, (medium), 4, (loose). December 30, 2025, at 9:44 p.m., indicated 1, (incontinent), 4, (large), 5, (watery).December 31, 2025, at 1:36 p.m., indicated 0, (continent), 3, (medium), 4, (loose).December 31, 2025, at 10:35 p.m., indicated 1, (incontinent), 4, (large), 5, (watery).Further review of the Bowel Continence/Movement reports from December 26 to December 31, 2025, indicated Resident 3 was having loose, watery stool for seven days (starting December 25, 2025, to December 31, 2025).A review of the Stool culture results dated December 28, 2025, indicated there was no salmonella/shigella. A review of the progress notes did not indicate that the physician was notified that the stool culture for C-diff was not completed as he ordered on December 25, 2025, and that the resident continued to have loose stool since December 25, 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes did not indicate documentation of treatment for the resident's loose stool.A review of Resident 3's SBAR (Situation, Background, Appearance, Review) Communication Form, dated December 31, 2025, at 4:23 p.m., indicated .Patient reported to have weight loss of -13.2 lbs./-8.1% x 1 week . drowsiness/always sleeping. RD [Registered Dietician] recommends assists with meals, cbc [complete blood count]/cmp [complete metabolic panel] .A review of Resident 3's Laboratory Results, indicated the following:December 23, 2025, WBC 8.44; andDecember 31, 2025, WBC 36.91 flagged as a critical result.A review of Resident 3's SBAR Communication Form, dated December 31, 2025, at 11:39 p.m., indicated, .Received a critical lab result: Elevated WBC - 36.91 . Further review of the document did not indicate any recommendations or interventions from the primary physician. On January 27, 2026, at 3:59 p.m., a telephone interview was conducted with the Registered Nurse (RN 1). RN 1 stated that on December 31, 2025, at approximately 11:30 p.m., she recalled that Resident 3 had a critical laboratory value for WBC of 36.91. RN 1 stated that she texted the doctor with critical laboratory value, and the doctor responded requesting when Resident 3 was admitted to the facility. RN 1 stated that Resident 3's admission date was provided to the doctor with no response. RN 1 stated that she endorsed the critical laboratory value to Licensed Vocational Nurse (LVN 3). RN 1 stated that on January 1, 2026, at approximately 2 a.m., Resident 3's vital signs became unstable and they called 911. RN 1 stated that Resident 3 had a pulse when the paramedics rendered care and transferred. RN 1 stated that the paramedic came into the facility and informed RN 1 that Resident 3 had passed away in the ambulance, time of death 2:38 a.m.On January 28, 2026, at 1:14 p.m., during an interview and concurrent record review, Licensed Vocational Nurse (LVN) 4 stated that if a resident had loose watery stool, they would notify the physician. LVN 4 stated that an order for a stool culture for Clostridioides difficile is a different test than a stool culture. LVN 4 verified that Resident 3's SBAR Communication Form dated December 25, 2025, indicated that the primary clinician recommendation indicated a stool culture for C-diff which was a different laboratory test from what was indicated in the order summary dated December 25, 2025. LVN 4 stated that the physician should have been notified when the wrong laboratory test was completed.On January 28, 2026, at 2:40 p.m., an interview was conducted with RN 2. RN 2 stated if a resident had laboratory results of a WBC at 36.91, the staff would notify the doctor immediately and follow any new orders.On January 28, 2026, at 3:16 p.m., an interview was conducted with the Assistant Director of Nursing (ADON), and she stated the following: Resident 3 had loose stool, and the physician recommended a C-diff panel (referring to stool culture for C-diff), so the staff should have completed a C-diff test. The ADON confirmed that a stool culture for C-diff should have been completed in accordance with the physician recommendation on December 25, 2025. A resident with a laboratory test result for WBC at 36.91 would be a critical laboratory value; and confirmed that the physician should have been notified; and Confirmed that when RN 1 received a response from the physician asking for the admission date, RN 1 should have followed up with the physician again on the resident's critical laboratory value.On February 20, 2026, at 2:53 p.m., a telephone interview was conducted with LVN 3. LVN 3 confirmed that he was in charge of Resident 3 from 11 p.m. to 7 a.m. on December 31, 2025. During this period, RN 1 instructed LVN 3 to monitor Resident 3 due to a critical laboratory value. LVN 3 explained that he performed visual checks on Resident 3 every 30 minutes to ensure normal breathing. He noted that critical laboratory value is considered an emergency and requires an immediate phone call to the physician rather than a text message. He also performed a bladder scan on Resident 3, during which she was easily aroused. However, when he checked on her again later, her breathing had become labored. Subsequently, he notified RN 1 and the Certified Nursing Assistant (CNA). LVN 3 stated RN 1 then proceeded to call 911.On March 2, 2026, at 3:47 p.m., a telephone interview was conducted with Resident 3's physician. Resident 3's physician stated that he was not informed that the c-diff culture that was ordered on December 25, 2025, had not been performed. Furthermore, the physician stated that if the resident was still having loose watery stool, a C-diff culture would have been important as if it was positive, he would have ordered antibiotics. In (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addition, he stated he ordered the staff for Resident 3 to be transferred to the GACH, but he was unaware that there was a delay in transferring the resident (Resident 3).A review of Resident 3's SBAR Communication Form dated January 1, 2026, at 2:05 a.m., indicated, .Blood Pressure 76/50 [normal range 110/70 to 120/80].Pulse 58 [normal range 60 to 100].Respirations 28 [normal range 16 to 20]. Pulse Oximetry [a small sensor, typically clipped to the fingertip, earlobe, or toe, uses light to detect how well oxygen is being delivered to the body's extremities] 68% [normal range 95% to 100%]. at around 12:45 am writer checked on the roommate and the resident while in the room. Resident no (sic) SOB [shortness of breath] or in distress, at around 2 am during rounds writer noticed resident have (sic) fast and labored breathing, immediately called the RN supervisor and taken (sic) vitals, RN supervisor assessed the resident and called 911, was offered oxygen therapy. MD notified about the residents (sic) condition. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: send resident to [name of hospital].A review of Resident 3's Progress Notes dated January 1, 2026, at 6:59 a.m., indicated .At around 12 am charge nurse was able to perform bladder scan with resident's permission, No SOB noted, able to respond to the writer, not in distress, at around 12:45 am writer checked on the roommate and the resident while in the room. Resident no (sic) SOB or in distress, at around 2 am during rounds writer noticed resident have (sic) fast and labored breathing, immediately called the RN supervisor and taken (sic) vitals, RN supervisor assessed the resident and called 911, was offered oxygen therapy. MD notified about the residents (sic) condition.A review of Resident 3's Progress Notes dated January 1, 2026, at 07:01 a.m., indicated, At 0205, this writer was notified by the charge nurse to assess the patient's oxygen and level of consciousness. This writer immediately went to assess the patient and noted that she was experiencing difficulty with labored breathing. The head of bed was elevated, and oxygen at 15 L[liters]/min [minute] via non-rebreather mask was initiated. The patient was also noted to have an altered mental status at this time. The patient remained responsive but continued to have labored breathing. 911 was called at approximately 0212. Paramedics arrived and assessed the patient; report and all paperwork were given by the charge nurse, including the patient's POLST [physician's order for life sustaining treatment] indicating DNR [do not resuscitate] status. The paramedics then left to transport the patient to [name of hospital]. At 0240, the patient's [family member] wasnotified (sic) of the transfer. At approximately 0245, one of the paramedics returned and informed staff that the patient had passed away at 0238 in the ambulance.Further review of the progress notes and SBAR from December 31, 2025, to January 1, 2026, indicated that resident was not transferred to the GACH until January 1, 2026, at 2:12 a.m., (2 hours after the WBC critical value of 36.91 was received by the facility on December 31, 2025, and 7 days after the resident was first observed with loose stool). Resident 3 passed away on January 1, 2026, at 2:38 a.m., in the ambulance.A review of the facility's policy and procedure titled Change in a Resident's Condition or Status, revised February 2021, indicated .1. The nurse will notify the resident's attending physician or physician on call when there has been a(an). d. significant change in the resident's physical/emotional/mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting) . 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.A review of the facility's policy and procedure titled, Lab and Diagnostic Test Results - Clinical Protocol, revised November 2018, indicated, .1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Review by Nursing Staff 1. When test results are reported to the facility, a nurse will first review the results. a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this (continued on next page)

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