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	03/25/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure effective discharge planning when the facility did not provide caregiver training on the necessary care required by Resident 1 prior to discharge on [DATE].This failure had the potential to cause anxiety to the resident and the resident's caregiver which could lead to inadequate home care and possible rehospitalization. Findings: A review of Resident 1's admission Record dated February 19, 2026, indicated an admission date of January 12, 2026, with diagnoses which included hypertensive heart disease with heart failure (long term high blood pressure has damaged the heart so it cannot pump blood as well as it should) and morbid obesity (extremely overweight). A review of Resident 1's Minimum Data Set (MDS - an assessment tool) dated February 13, 2026, indicated a Brief Interview for Mental Status (an assessment tool for cognitive functioning) score of 14 (cognitively intact). A review of Resident 1's MDS Section GG dated January 19, 2026, indicated Resident 1 required partial/moderate assistance (the resident can do part of the activity but needs help from another person for less than half of the effort) for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, and toilet transfer. A review of Resident 1's progress notes titled Case Manager Note, dated February 3. 2026, indicated, .Spoke with (Name of Resident 1's friend), designated DPOA [Durable Power of Attorney], to review and further discuss the patient's discharge plan. (Name of Resident 1's friend) confirmed that the patient will be returning home upon discharge and stated that his (Friend's family member), along with a close friend, will assist with the patient's ADL needs, including support with mobility, personal care, meals, and supervision as needed.The patient was also engaged in discussion and clearly expressed his preference to return home, stating he does not want placement in a board and care setting at this time. A review of Resident 1's physician order dated February 4, 2026, indicated, Benefit Exhaust 2/6/26 (February 6, 2026) discharge 2/7/26 (February 7, 2026) to (home address) . Further review of Resident 1's record indicated there was no documented evidence that caregiver training was provided to the party responsible or any designated caregiver prior to the planned discharge date for February 7, 2026. In addition, there was no documented evidence that the facility rescheduled the caregiver training when the caregiver training was not completed prior to the planned discharge date on February 7, 2026. On February 7, 2026, at 9 a.m., Certified Nursing Assistant (CNA 1) was interviewed. CNA 1 stated Resident 1 required assistance with daily activities. On February 7, 2026, at 9:10 a.m., an interview was conducted with the Responsible Party (RP) for Resident 1. The RP indicated that the facility intended to discharge Resident 1 on that day (February 7, 2026). Additionally, the RP expressed uncertainty regarding the ability to provide the necessary care for Resident 1 following discharge. On February 23, 2026, at 2:25 p.m., the Director of Rehabilitation (DOR) was interviewed. The DOR stated Resident 1's ability to ambulate and work with therapy varied. The DOR stated there was no documentation indicating a caregiver training was provided or appointments were made to coordinate with the caregiver for training. The DOR stated for Resident 1, the physical therapist recommended home health, caregiver, bariatric front wheel walker, wheelchair, and oxygen upon discharge. On February 25, 2026, at 10:55 (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., the Case Manager (CM) was interviewed. The CM stated Resident 1 wanted to be discharged home. The CM stated Resident 1 was expected to be discharged home on February 7, 2026, when the state agency came. The CM stated caregiver training was offered to Resident 1?s RP but was not completed and no caregiver training was completed for Resident 1's designated caregiver. On February 25, 2026, at 11:50 a.m., the Director of Nursing (DON) was interviewed. The DON stated that the rehabilitation department was responsible for providing caregiver training which included the activities of daily living. The DON stated, Resident 1's caregiver should have been provided caregiver training or any other designated caregiver which would be involved in the resident's care to ensure the resident is safe at home. The DON stated, if the caregiver training was not completed, the resident should not be discharged home and would not be considered a safe discharge. A review of the facility policy titled, Discharge Summary and Plan, dated March 2025, indicated, .Discharge Planning.to ensure a safe transition from the facility to the post-discharge setting.based on resident assessment.Discharge planning identifies the discharge destination, and ensures that it meets the resident's health and safety needs.Discharge to the Community.facility determines if appropriate and adequate support is in place.may include the capacity of the resident's caregivers at home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide the resident or resident representative, and the Ombudsman with a new written notice of proposed transfer or discharge when a resident originally scheduled for discharge to home was instead discharged to a board and care facility. This failure had the potential to result in Resident 1 and his representative not receiving adequate notification of the change in discharge destination, nor the opportunity to appeal, potentially impacting their rights and the discharge process. Additionally, the Ombudsman not receiving the new proposed discharged notice led to a missed opportunity for the Ombudsman to advocate for the resident's safe discharge.Findings: A review of Resident 1's admission Record dated February 19, 2026, indicated an admission date of January 12, 2026, with diagnoses which included hypertensive heart disease with heart failure (long term high blood pressure has damaged the heart so it cannot pump blood as well as it should) and morbid obesity (extremely overweight). A review of Resident 1's physician order indicated the following: -Dated February 4, 2026, Benefit Exhaust 2/6/26 (February 6, 2026) discharge 2/7/26 (February 7, 2026) to (home address) . -Dated February 13, 2026, .discharge .board and care. A review of Resident's 1 document titled Notice of Proposed Transfer/Discharge, dated February 4, 2026, indicated .Effective Date: 2/7/26 (February 7, 2026) .Transfer/Discharge to. (home address) . There was no documented evidence that a new written notice of proposed transfer/discharge reflecting the new destination of board and care on February 13, 2026, was provided to the resident/representative party (RP) and the Ombudsman. A review of Resident 1's Discharge/Transfer Summary, dated February 13, 2026, indicated resident was discharged to a board and care. On February 23, 2025, at 4:10 p.m., the Case Manager (CM) was interviewed. The CM stated that a written notice of proposed discharge or transfer was given once she was aware of resident's discharge. The CM stated that the Social Service Designee (SSD) was responsible for providing the written notice of proposed transfer/discharge form to the Ombudsman, resident and the resident representative. The CM stated she would provide a new form when there were changes in the discharge plan. The CM stated she did not provide a new copy to the Ombudsman, for Resident 1. The CM stated, providing a written notice would allow the resident to appeal the discharge decision and help ensure safe discharge. On February 25, 2026, at 11:50 a.m., the Director of Nursing (DON) was interviewed. The DON stated that either the Social Services Director (SSD) or the Case Manager (CM) should review the notice with the residents and/or their representative to discuss the new plan, ensure a safe discharge, and provide the opportunity for an appeal. The DON stated the written notice of proposed transfer/discharge should be completed by the SSD or CM and sent by fax to the Ombudsman. Additionally, the DON stated that a new notice of transfer/discharge should have been prepared for the discharge date of February 13, 2026, for Resident 1. The DON indicated that there was no documentation confirming that this new form had been provided to the resident, the resident representative, or the Ombudsman, for Resident 1. A review of the facility policy titled, Transfer or Discharge Notices, dated March 2025 indicated, .Residents (or resident representatives) are notified of an impending transfer or discharge.in writing.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman.given as soon as it is practicable but before the transfer or discharge.For significant changes, such as a change in the transfer or discharge destination, a new notice will be given.