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	02/25/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35314 Based on interviews, record review, and facility policy review, the facility failed to follow-up with the local authority for the completion of a Level II Preadmission Screening and Resident Review (PASARR) for 1 (Resident #93) of 2 sampled residents reviewed for PASARRs. Findings included: Review of a facility policy titled, California Preadmission Screening and Resident Review, effective 07/01/2020, revealed It is the policy of this facility that a Preadmission Screening and Resident Review Level I is completed to identify individuals who have a mental illness (MI) or intellectual disabilities (ID) and ensure that these residents receive the services and setting determined by the California Department of Health Care Services (DHCS). Level II Full Evaluation should be conducted by a DHCS Contractor for determination when the Level I Screen identifies the resident have Mental Illness (MI) or Intellectual Disability (ID). The policy specified, 6. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II. A review of Resident #93's Admission Record revealed the facility the resident on 11/24/2023, with diagnoses to include schizophrenia and anxiety disorder. A review of Resident #93's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Per the MDS, the resident had active diagnoses to include anxiety disorder, depression, psychotic disorder, and schizophrenia. A review of Resident #93's care plan, initiated on 12/05/2023, revealed the resident received antipsychotic medications related to medical diagnoses that included schizophrenia and psychosis. A review of a letter from the State Department of Health Care Services Department of Health Care Services, addressed to the Administrator and dated 11/27/2023, revealed Resident #93 was unable to participate in the Level II evaluation. During an interview on 02/24/2024 at 3:32 PM, the Director of Medical Records stated all PASARR calls and questions were forwarded to the Assistant Director of Nursing (ADON). (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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/22/2024 at 8:27 AM, the ADON acknowledged Resident #93 was in the facility at the time the Level II evaluation was scheduled. During an interview on 02/22/2024 at 8:48 AM, the MDS Registered Nurse (RN) stated he was unaware Resident #93 was not available for the Level II evaluation. The MDS RN stated facility staff did not follow-up with the local authority to ensure Resident #93's Level II evaluation was completed. During an interview on 02/24/2024 at 1:27 PM, the Director of Nursing (DON) stated the ADON was responsible for the PASARR process. According to the DON, the ADON should have notified the local authority immediately so that Resident #93 could receive the appropriate treatment services.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 35314 Based on record review, interviews, and facility policy review, the facility failed to submit a Level I Preadmission Screening and Resident Review (PASARR) for 1 (Resident #63) of 2 sampled residents reviewed for PASARRs. Findings included: Review of a facility policy titled, California Preadmission Screening and Resident Review, effective 07/01/2020, revealed It is the policy of this facility that a Preadmission Screening and Resident Review Level I is completed to identify individuals who have a mental illness (MI) or intellectual disabilities (ID) and ensure that these residents receive the services and setting determined by the California Department of Health Care Services (DHCS). The policy revealed 3. The 'Resident Review (RR) (Status Change)' is selected if the resident has already been admitted to the facility and the facility is updating the existing PASRR [PASARR] on file for either of the following reasons: a. The resident stay has exceeded the 30-day exempted hospital discharge. The Resident Level I 6170 should be submitted by the 40th calendar day after admission for such cases. A review of Resident #63's Admission Record revealed the facility originally admitted Resident #63 on 07/26/2023 and readmitted the resident on 12/19/2023. The Admission Record indicated the resident had diagnoses that included bipolar disorder and anxiety disorder. A review of Resident #63's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2023, revealed the resident had a Brief Interview Mental Status (BIMS) of 15, which indicated the resident was cognitively intact. The MDS revealed the resident had an active diagnosis of bipolar disorder. A review of Resident #63's care plan, initiated on 01/09/2024, revealed the resident received anti-anxiety medication related to a medical diagnosis of anxiety. A review of letter from the State of California-Health and Human Services Agency Department of Health Care Services, dated 11/07/2023, revealed if Resident #63 remained in the nursing facility longer than 30 days, the facility should submit a new Level I screening as a resident review on the 31st day. During an interview on 02/21/2024 at 2:13 PM, the Assistant Director of Nursing (ADON) acknowledged a new Level I screening for Resident #63 was not submitted because she was not aware the letter indicated instructions to resubmit a Level I evaluation if the resident remained in the facility longer than 30 days. During an interview on 02/21/2024 at 2:50 PM, the MDS Registered Nurse (RN) stated the facility made a mistake and did not complete a new Level I screening for Resident #63. The MDS RN stated he was not aware of the letter that specified the facility should resubmit a new Level I evaluation on the 31st day. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/24/2024 at 1:27 PM, the Director of Nursing stated that the ADON was responsible for the submission of the Level I screening. During an interview on 02/24/2024 at 3:47 PM, the Administrator stated the facility should have called on the 31st day to ensure a Level I screening was completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49044 Based on record reviews, interviews, and facility policy review, the facility failed to schedule physician ordered follow-up appointments for 2 (Resident #111 and Resident #188) of 25 sampled residents. Findings included: Review of a facility policy titled, Resident Appointments, dated March 2023, revealed Our facility has set the process on how appointments are made from the initial consult [consultation]/order to actual transport. Procedure: 1. Entering the initial order for consult in [the electronic medical record] to see a specialist falls on the RN [registered nurse] responsibility. 2. RN prints the order and place in the Case Manager's slot located in the station labeled Case Manager. 3. Case Manager collects the consult order and refer to the designated business office clerk to call the health plan/medical group for authorization as needed. 4. Business Office Clerk should note the order with the authorization number or simply write no auth [authorization] required with the case manager's name. 5. Once the schedule for the appointment is set, business office clerk enters the order in [the electronic medical record] and communicate to CM [case manager] via email. 6. Business Office Clerk to place the noted order in the purple folder inside the yellow appointment binder. 1. A review of Resident #111's Admission Record, revealed the facility admitted the resident on 12/26/2023, with diagnoses that included a displaced fracture of shaft of the left clavicle and unspecified dislocation of the right ulnohumeral joint (part of the elbow joint). A review of Resident #111's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A review of Resident #111's orthopedic surgery consultation from the local hospital dated 12/19/2023, revealed the resident was to follow-up in clinic this week for an outpatient evaluation. A review of Resident #111's trauma surgery consultation from the local hospital dated 12/19/2023, revealed the orthopedist recommended outpatient follow-up for the resident. A review of Resident #111's Admission Data Collection and Baseline Care Plan, dated 12/26/2023, revealed the resident had a post-operation follow-up appointment with an orthopedic surgeon. A review of Resident #111's Order Summary Report, for the time period 12/26/2023 to 02/29/2024, revealed an order dated 12/29/2023, that instructed staff to arrange post-operation follow up with the orthopedic surgeon, During an interview on 02/22/2024 at 2:28 PM, the Administrative Assistant/Case Manager Assistant (AA/CMA) stated when new residents were admitted to the facility from the hospital, he looked to see if there were any appointments the resident needed. According to AA/CMA, he tried to schedule an orthopedic appointment for Resident #111, but he was not sure what happened. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/23/2024 at 9:30 AM, the Director of Nursing (DON) stated that staff were in the process of scheduling Resident #111's orthopedic appointment. The DON acknowledged the appointment should have been scheduled when the resident admitted to the facility. The DON confirmed the facility missed scheduling Resident #111's orthopedic appointment. During an interview on 02/25/2024 at 8:35 AM, the Administrator stated he expected staff to handle appointments per the facility policy. 2. A review of Resident #188's Admission Record, revealed the facility admitted the resident on 01/31/2024, with diagnoses that included disorders of kidney and ureter, acute kidney failure, artificial openings of the urinary tract status, and hydronephrosis (swelling of one or both kidneys). A review of Resident #188's hospital discharge summary, electronically signed by a physician and dated 01/25/2024, revealed the follow-up/discharge instruction indicated the resident was to follow-up with an internal medical doctor within five to seven days, an oncologist within one to two weeks, an urologist within three to four weeks, and schedule an appointment with a hematologist/oncologist within one to two weeks. A review of Resident #188's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/07/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A review of Resident #188's Order Summary Report, for active orders as of 02/21/2024, revealed orders, dated 02/03/2024, that instructed staff to arrange an appointment with an oncologist within one to two weeks, an urologist within three to four weeks, and to schedule an appointment with a hematologist/oncologist. During an interview on 02/21/2024 at 10:13 AM, Resident #188 stated no one had spoken to them about any follow-up appointments after their hospital stay. The resident stated they had not had any scheduled follow-up appointments. During an interview on 02/22/2024 at 2:28 PM, the Administrative Assistant/Case Manager Assistant (AA/CMA) stated he scheduled resident appointments, called the physicians' offices, and organized transportation. According to the AA/CMA, he had not received anything from a case manager to schedule appointment for Resident #188. During an interview on 02/25/2024 at 8:35 AM, the Administrator stated he expected staff to handle appointments per the facility policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49044 Based on record review, interviews, and facility policy review, the facility failed to have evidence to indicate a pharmacy recommendation was reviewed by the physician for 1 (Resident #10) of 5 sampled residents reviewed for medication regimen review (MRR). Findings included: Review of a facility policy titled, Medication Regimen Reviews, revised in May 2019, revealed, The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. The policy indicated, 8. Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: 1. The resident's name; b. The name of the medication; c. The identified irregularity; and d. The pharmacist's recommendation. Per the policy, 12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. The policy specified, 15. Copies of medication regimen reports, including physician responses, are maintained as part of the permanent medical record. A review of Resident #10's Admission Record, revealed the facility admitted the resident on 01/15/2024, with diagnoses that included heart failure and dementia. A review of Resident #10's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. A review of Resident #10's Order Summary Report, with active orders as of 02/23/2024, revealed an order dated 01/16/2024, for primidone oral tablet 50 milligrams (mg), give two tablets by mouth one time a day for seizure. A review of the Consultant Pharmacist's Medication Regimen Review, for recommendations created between 02/01/2024 and 02/07/2024, revealed a recommendation for a primidone level for Resident #10. During an interview on 02/22/2024 at 3:15 PM, the Director of Nursing (DON) stated he was responsible to ensure the pharmacy recommendations were followed up on. The DON said he delegated the pharmacy recommendations out to one of his quality assurance nurses to ensure completion. The DON stated the Consultant Pharmacist's Medication Regimen Review for 02/07/2024 was delegated to Licensed Vocational Nurse (LVN) #34. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 02/23/2024 at 10:15 AM, LVN #34 stated she sent the pharmacy recommendations in a text message to the physician. LVN #34 said she documented in the resident's electronic medical record when she received a response from the physician and the physician's response. However, LVN #34 stated she only documented in the resident's medical record when the physician responded with orders for changes in the resident's medications or laboratory orders and did not document if the physician did not agree with the pharmacist's recommendations. LVN #34 stated she did not recall if the physician responded to the recommendations for Resident #10's laboratory request and acknowledged there was no documentation to indicate the physician was notified of the pharmacist's recommendation. During an interview on 02/24/2024 at 1:11 PM, the DON stated the physician addressed the pharmacist's recommendation for Resident #10 but did not document it. According to the DON, LVN #34 followed-up on the recommendation for Resident #10 but failed to document. During an interview on 02/25/2024 at 8:35 AM, the Administrator stated he expected follow up on the pharmacy recommendations to be done correctly and accurately. The Administrator s stated staff should document the recommendations made by the physician, to include whether the physician agreed or disagreed with the pharmacist's recommendation, in the resident's progress notes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35314 Based on observation, interviews, and facility policy review, the facility failed to chicken was thawed in a safe manner for 106 of 113 sampled residents who received food from the kitchen. Findings included: Review of a facility policy titled General HACCP [Hazard Analysis and Critical Control Point] Guidelines for Food Safety, with a copyright date of 2017 revealed, 6. Safe Thawing Practices a. Thaw meat, fish and or poultry in a refrigerator in a drip proof container and in a way that prevents cross contamination. b. Completely submerge the item in clean running water that is running fast enough to agitate and float off loose ice particles. c. Thaw the item in a microwave oven using the defrost mode if it is to be cooked immediately after thawing. d. Thaw as part of the cooking process. During a concurrent observation and interview on 02/20/2024 at 8:44 AM, four bags of chicken were observed in water in a sink in the facility's kitchen. There was not a continuous flow of cold water on the four bags of chicken. Dietary Aide/Assistant Supervisor (DA/AS) #35 stated the bags of chicken were placed in the sink by Cook #33. DA/AS #35 turned the cold water on so there would be a continuous flow of cold water on the four bags of chicken and stated cold water was used to thaw the chicken. During an interview on 02/21/2024 at 1:02 PM, Cook #33 stated the process for thawing meat was to place the meat in a continuous flow of cold water. Cook #33 stated he placed the chicken in the sink with hot water, because he wanted to thaw the four bags of chicken more quickly. During an interview on 02/20/2024 at 11:36 AM, the Dietary Supervisor stated she was informed by DA/AS #35 of the concern regarding how four bags of chicken was being thawed. According to the Dietary Supervisor, she informed DA/AS #35 to discard the chicken. During a follow-up interview on 02/23/2024 at 9:03 AM, the Dietary Supervisor stated staff should thaw chicken according to the facility policy. During an interview on 02/24/2024 at 1:33 PM, the Director of Nursing stated kitchen staff should thaw meat under a flow of continuous flow of cold water. During an interview on 02/24/2024 at 3:55 PM, the Administrator stated his expectation was for the kitchen staff to follow the food and safety guidelines for how meats should be thawed.

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on document reviews, interviews, review of the Centers for Disease Control and Prevention (CDC) guidelines/recommendations, and the facility policy, the facility failed to maintain an infection prevention and control program to prevent the transmission of Coronavirus Disease 2019 (COVID-19) to staff and residents on 4 of 4 units. Specifically, the facility failed to conduct contact tracing (identification and monitoring of individuals who have been exposed to a disease to prevent further spread) for staff during an outbreak of COVID-19. The facility determined usage of N95 respirators (source control) negated the CDC recommendation/guidelines for testing individuals' exposure to COVID-19. Subsequently, the facility failed to test all residents and staff who had been in close contact with others who had COVID-19. The facility further failed to conduct broad-based COVID-19 testing when contact tracing failed to halt transmission of COVID-19 per the facility's policy. The failed practices had the potential to affect all 111 residents who resided in the facility. As of 02/22/2024, the facility had eight residents and two staff that tested positive for COVID-19. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.80 (Infection Control) at a scope and severity of L. The IJ began on 01/26/2024 when Resident #76 tested positive for COVID-19 and the facility failed to do appropriate contact tracing and testing of everyone that had contact with Resident #76. Subsequently, Resident #63, Resident #45, Resident #81, Resident #251, Resident #252, and Resident #288, who resided on different units of the facility, tested positive for COVID-19 through 02/22/2024. The Administrator and Director of Nursing (DON) were notified of the IJ and provided the IJ template on 02/23/2024 at 6:20 PM. A Removal Plan was requested. The Removal Plan was accepted by the state survey agency on 02/24/2024 at 5:50 PM. The IJ was removed on 02/25/2024 at 11:35 AM, after the survey team performed onsite verification of the Removal Plan implementation. Noncompliance for F880 remained at the lower scope and severity of widespread, with actual harm that was not immediate jeopardy for F880. Findings included: A review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 05/08/2023, revealed Responding to a newly identified SARS-CoV-2-infected [severe acute respiratory syndrome coronavirus 2] HCP [health care personnel] or resident. - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility policy titled, COVID-19 Policies and Procedures COVID-19 Mitigation Plan, revised 09/01/2023, revealed Post Exposure and Response Testing * Immediate investigation of potential outbreak should be performed when one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility. SNFs [skilled nursing facilities] should perform contact tracing within the facility to identify any HCP who have had a higher-risk exposure or residents who may have had high-risk close contact with the individual with SARS-CoV-2 infection: All HCP who have had a higher-risk exposure without source control and residents who have had close contacts, regardless of vaccination status, should be tested promptly (but not earlier that 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure. The policy revealed, If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection. A facility-wide or group level approach with quarantine for exposed groups should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. A review of the facility COVID-19 Outbreak Log, dated 01/24/2024, revealed Resident #77 was positive for COVID-19 upon admission to the facility on [DATE]. Further review revealed four days later, Licensed Vocational Nurse (LVN) #1 had cold symptoms and tested positive for COVID-19 on 01/26/2024. In addition, Resident #76, who resided on the same unit as Resident #77 had shortness of breath and tested positive for COVID-19 on 01/26/2024. There was no documented evidence the facility conducted contact tracing when LVN #1 tested posted for COVID-19 to determine whether residents had been exposed to LVN #1. During an interview on 02/23/2024 at 9:15 AM, the Infection Preventionist (IP) stated LVN #1 cared for residents the day before (01/25/2024) the nurse tested positive for COVID-19. According to the IP. the facility did not test any of the residents LVN #1 cared for as LVN #1 wore an N95 respirator. A review of the facilityCOVID-19 Outbreak Log, dated 02/07/2024, revealed Resident #63 had a cough and tested positive for COVID-19 on 02/05/2024, Resident #45 had a cough and shortness of breath and tested positive for COVID-19 on 02/06/2024, Resident #81 had a cough and tested positive for COVID-19 on 02/06/2024, and the Director of Environmental Services had a fever, headache, body aches, and cough and tested positive for COVID-19 on 02/07/2024. There was no documented evidence the facility conducted contact tracing when the Director of Environmental Services tested positive for COVID-19 to determine whether residents had been exposed to the Director of Environmental Services. A review of the facility COVID-19 Outbreak Log, dated 02/11/2024, revealed Resident #251 had a headache, nausea, and fatigue and tested positive for COVID-19 on 02/11/2024. There was no documented evidence the facility completed contact tracing when Resident #251 tested positive for COVID-19 to determine who had been exposed to the resident. A review of the facility COVID-19 Outbreak Log, dated 02/19/2024, revealed Resident #252 had shortness of breath and tested positive for COVID-19 on 02/16/2024. A review of the facility COVID-19 Outbreak Log, dated 02/22/2024, revealed Resident #288 tested positive for COVID-19 on 02/21/2024. (continued on next page)

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 02/25/2024

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.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 02/23/2024 at 9:15 AM, the IP stated the facility did not test any staff during the COVID-19 outbreak because staff woreN-95 respirators, and the facility did not consider the staff to have been exposed to COVID-19. During an interview on 02/23/2024 at 5:10 PM, Clinical Care Coordinator (CCC) #3 stated she was the IP at the facility for two years prior to the current IP. According to CCC #3, the facility believed staff usage of N95 respirators prevented exposure to COVID-19. During an interview on 02/23/2024 at 11:27 AM, the DON stated facility staff had been wearing N95 respirators since December 2023. During an interview on 02/23/2024 at 3:17 PM, a representative from the local health department stated the facility should complete contact tracing for any resident or staff that were exposed, whether the staff wore an N95 respirator or not. During a follow up interview on 02/23/2024 at 4:16 PM, the DON stated he did not believe staff needed to complete COVID-19 testing because staff wore N95 respirators. During an interview on 02/24/2024 at 9:45 AM, the IP stated she was not able to determine how each resident contracted COVID-19. During an interview on 02/23/2024 at 11:24 PM, the Administrator stated the facility did not test staff after a resident tested positive for COVID-19 if staff wore source control (N95 respirator). During an interview on 02/23/2024 at 6:32 PM, the Administrator stated the staff usage of the N95 respirators negated their need to be tested for COVID-19. On 02/24/2024 at 5:50 PM, a Removal Plan was submitted by the facility and accepted by the state survey agency. It read as follows: 1. How corrective action was taken for identified resident. (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On February 23, 2024, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist (IP), Quality Assurance Nurse (QAN) immediately tested those on scheduled PM shift on the 23rd, NOC [night] shift on the 24th and AM shift on the 24th. In addition, the Department Heads reached out to staff not scheduled yesterday or today to check their availability to come in and be tested and have an in-service. The scheduled staff and a large portion of the unscheduled staff who were available were tested and available residents and staff for COVID-19 exposure even if they were near the positive resident or not, and no additional residents or staff had positive covid test results. The DON, ADON, IP and QA Nurse reviewed and updated care plans based on residents needs for all those identified within the Immediate Jeopardy (IJ) documentation. In addition, they reviewed current practices during the PM shift on February 23, 2024, to ensure staff are exercising appropriate infection control procedures. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist (IP), Quality Assurance Nurse (QAN) were in-serviced and instructed, by the Corporate Nurse Consultant, on what was needing to be updated in the facility mitigation plan dated February 23, 2024 as well as general infection control and transmission based precautions to include but not limited to following: immediate investigation of potential outbreak should be performed when one or more COVID-19 positive individuals (resident or staff) is identified in the facility, immediate contact tracing by the infection preventionist or designee within the facility to identify any health care provider who have had higher risk exposure or residents who may have had high-risk close contact with the individual with SARS-CoV-2 infection, testing of residents and staff during an outbreak of COVID-19, on days 1, 3, and 5 following exposure, screening of all visitors and staff prior to entering the care area, correct donning and doffing of personal protective equipment of all staff and visitors in the COVID-19 unit and in rooms under transmission-based precaution, and how to recognize and report signs and symptoms of COVID-19 infection to prevent transmission. In consultation with the DON, IP, Director of Staff Development (DSD) and ADON began in-service of all staff verbally and in writing on February 23, 2024, through February 24, 2024. The in-service will be provided to all staff, prior to starting their shift. As the staff report to work for their shift after the 23rd of February, they will be in-serviced prior to starting their shift. This will be done in the Director of Staff Development (DSD) or area that accommodates the number of staff being in-serviced. The in-service will include the facility's revised new mitigation plan and guidelines dated February 23, 2024, general infection control and transmission based precautions to include but not limited to following: immediate investigation of potential outbreak should be performed when one or more COVID-19 positive individuals (resident or staff) is identified in the facility, immediate contact tracing by the infection preventionist or designee within the facility to identify any health care provider who have had higher risk exposure or residents who may have had high-risk close contact with the individual with SARS-CoV-2 infection, testing of residents and staff during an outbreak of COVID-19, on days 1, 3, and 5 following exposure. screening of all visitors and staff prior to entering the care area, correct donning and doffing of personal protective equipment of all staff and visitors in the COVID-19 unit and in rooms under transmission-based precaution, and how to recognize and report signs and symptoms of COVID-19 infection to prevent transmission. The record of education was filed and placed in the education binder by the Director of Nursing (DON). The Quality Assessment and Performance Improvement (QAPI) Committee met on February 24, 2024, to review and approve the QAPI which was created to address this issue. The Medical Director was made aware on February 23, 2024, regarding the IJ and the direction we were taking in the removal plan. The QAPI is part of our Plan of Correction (POC) as we move forward and includes system changes, monitoring and education as needed. The following QAPI Committee members were involved: (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of facility Sars-Cov2 Rapid Antigen Testing (POC) forms revealed all residents were tested on [DATE] or 02/23/2024 and all were negative for COVID-19. On 02/24/2024 at 6:00 PM, all staff listed on a facility working assignment sheet were verified to have been tested . A review of sign-in sheets revealed the Nurse Consultant instructed the DON, ADON, IP, and QAN on needed updates to the facility's mitigation plan. Interviews with the DON, ADON, IP and QAN revealed they had received education regarding the updated plan. A review of a facility document revealed the DON had a telephone conversation with the medical director regarding the IJ and the removal plan. A review of the facility's updated COVID-19 Mitigation Plan for Testing, Quarantine, Isolation, and Vaccination of Health Care Personnel (HCP) and Residents revised 02/23/2024 revealed it was up to date with current CDC guidelines. The facility's mitigation plan was revised to include all HCP who had a higher-risk exposure and residents who had close contact, regardless of vaccination status, should be tested promptly (but not earlier than 24 hours after exposure) and, if negative, again at day three and day five after the exposure. A review of In Service Compliance Training Record revealed staff sign-in sheets dated 02/23/2024 and 02/24/2024 revealed staff were educated on the updated mitigation plan and testing requirements following exposure. Interviews with staff from all three shifts and all disciplines revealed staff were able to verbalize the testing requirements for COVID-19 after being exposed to a resident or staff that had confirmed COVID-19. A review of a facility Random Assessment of Staff Competency dated 02/23/2024, revealed the facility randomly audited staff donning and doffing personal protective equipment, handwashing, visitor screening, and signage. The facility developed a form titled Rounding Tool for COVID-19 to be used for daily rounds and quality assurance and performance improvement (QAPI) audit tools were reviewed. A review of a facility QA/QAPI Committee Meeting Sign-In revealed the facility held a QAPI meeting on 02/24/2024.