STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555747	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Murrieta Health and Rehabilitation Center	24100 Monroe Avenue Murrieta, CA 92562

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for two of four residents (Residents A and B), were free from abuse when: 1. For Resident A, Certified Nursing Assistant (CNA) 1 refuses to take care of the resident and stated I am not your slave, and 2. For Resident B, CNA 1 provided care to the resident in a rough manner. These failures had the potential for Residents A and B to experience physical and emotional distress from the abuse from CNA 1. Findings: On June 11, 2025, at 9:50 a.m., an unannounced visit was made to the facility, for the investigation of an allegation of abuse. On June 11, 2025, at 10:00 a.m., an interview was conducted with the Administrator (Admin). The Admin stated on the morning of May 26, 2025, he had received a call from Licensed Vocational Nurse (LVN) 1, regarding CNA 1 was being rough with Resident B, and an allegation of abuse was reported. The Admin stated CNA 1 was interviewed and said there was a change in assignments when he first came in, and when he went to change Resident B, the resident was being combative and was difficult to change. On June 11, 2025, at 10:30 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated CNA 1 reported to Resident B's room and saw the resident's leg extended off the bed and was repositioned. The ADON stated CNA noted Resident B was soiled and the resident began to yell. The ADON stated LVNs 1 and 2 came into the room and CNA 1 told the LVNs that the resident was soiled and needed to be changed. The ADON stated LVN 1 explained to CNA 1 that Resident B was stiff and should be changed in a gentle manner, and CNA 1 responded to them the resident was being combative, soiled and needed to be changed. The ADON stated LVN 1 reported that when both LVNs went to the resident's room after they heard screaming, they saw CNA 1 was providing care to Resident B in an aggressive manner by moving the resident side to side and removing sheet from under the resident while the resident was yelling he hurt me, he hurt me. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 11, 2925, at 11:45 a.m., an interview was conducted with the Social Service Director (SSD). The SSD stated conducted interviews of other residents regarding the care being provided by CNA 1. The SSD stated Resident A (who was across Resident A's room) told her CNA 1 had an attitude problem. On June 11, 2025, at 12:30 p.m., a review of Resident B's medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (nerve cell damage in the brain that affects movement, includes tremors), dementia (a group of conditions with impairment of brain function, memory loss and judgement). A review of Resident B's History and Physical, dated May 24, 2025, indicated, .Patient is frail, confused, and slow. Dementia impacts is ability to make independent decisions .Requires moderate to maximum assistance for bed mobility . A review of Resident B's Progress Notes, dated May 26, 2025, at 9 a.m., indicated, .around 0720 (7:20 a.m.) resident was screaming in (room number) LVN (name of LVN) and I ran to see wat (sic) happened and saw cna (name of CNA) changing resident very aggressively pushed resident to the side pulled sheet out form (sic) under him using force stating he's all shitty know (sic) one changed him did not acknowledge resident at all resident continues to scream he hurt me. Approached cna to please be more gentle with patient yeall at me he was being combative resident was not being combative upon my observation .reported to RN (Registered Nurse name) on duty, she proceeded to call ADON (Assistant Director of Nursing) .spoke with Administrator explained to send cna (CNA) home suspended, get statement, notify family, notify MD (physician) .fax over soc 341 to ombudsman . A review of Resident B's care plan, dated May 26, 2025, indicated, .The resident has a history of behavior problem r/t (related to) combative behavior during ADL (Activities of Daily Living) care, screaming, refuses ADL .Interventions .Anticipate and meet his ADL needs .Educate staff on how to handle resident during ADL care . A review of the investigation notes with resident interviews, dated May 27, 2025, indicated, Resident A stated CNA 1 .did not want to get him up and had another CNA do it, [name-CNA 1] responded I'm not your slave . On June 11, 2025, at 1:30 p.m., an interview was conducted with Resident A. Resident A stated CNA 1 had a bad attitude on May 26, 2025, and that CNA 1 refused to provide Resident A care. Resident a stated CNA 1 was upset and stated to Resident A I'm not your slave and he was taken back by CNA 1's comment to him. Resident A stated CNA 1 was upset about something that morning (May 26, 2025). Resident A stated he does require a lot of care, because of his medications and diagnoses requiring a lot of assisance from staff. Resident A stated he heard a scream across the hall from his room, he saw the nurses run in the room, and then the police came. On June 11, 2025, at 3:25 p.m., an interview was conducted with LVN 2. LVN 2 stated on the morning of May 26, 2025, the following happened: - LVN 2 was at the nurse's station charting, when she heard yelling coming from Resident B's room; - Both LVNs went immediately to Resident B's room, and observed CNA 1 trying to pull Resident B over onto his right side with both of his legs bent, and Resident B was yelling you're hurting me ; (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA 1 was trying to pull a sheet out from underneath Resident B and was pushing and pulling the resident back and forth to do so; - CNA 1 stated to both of the LVNs the resident was soiled, and needed to be changed; - LVN 2 went to comfort Resident B's roommate, who was visibly upset, while CNA 1 left the room to get linens; - LVN 1 comforted Resident B and had stopped yelling; - When both the LVNs came back to the nurse's station, they discussed what was observed inside the resident's room, CNA 1 handling Resident B in a rough manner, CNA 1 was hurting Resident B, and not addressing Resident B while changing him; - CNA 1 said Resident B was being combative, however LVN 2 did not observe Resident B acting combative. Both LVNs decided to report the incident of abuse to the Admin. LVN 2 stated she had not met or worked with CNA 1 until the morning of May 26, 2025. LVN 2 stated CNA 1 came in to the facility upset, and got more upset with his assignment, and told the charge nurse, he would not take care of Resident A. LVN 2 stated CNA 1 was yelling in the hallway he refused to take care of Resident A. On June 11, 2025, at 4:00 p.m., a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (a chronic, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body), COPD (chronic obstructive pulmonary disease - a lung disease which blocks airflow and makes it difficult to breathe), and congestive heart failure (CHF- a condition where the heart does not pump blood as well as it should). On June 13, 2025, at 8:20 a.m., an interview was conducted with LVN 1. LVN 1 stated the following happened the morning of May 26, 2025: - The unit was short staffed by two CNAs, CNA 1 was upset he had an assignment he did not want to work; - CNA 1 did not want to work with Resident A, as he responded loudly, I'm not doing it, he treats me like a slave. LVN 1 stated Resident A heard CNA 1's comment and was shocked; - Resident A is very particular and preferred things done for him in a certain way, and it could take a long time for the staff when working with him. Resident A could be difficult but the resident was young and had a debilitating diagnosis; - LVNs 1 and 2 were at the nurse's station and heard screaming coming from Resident B's room, went immediately to the room and observed CNA 1 pushing and pulling on Resident B, and Resident B was yelling he hurt me. CNA 1 was attempting to clean up Resident B, who was on his right side, and CNA 1 had pulled the draw sheet out from under Resident B and stated, he is f--king shitty; and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident B's roommate was upset and LVN 2 went to comfort the resident. LVN 1 stated she calmed down Resident B and CNA 1 was able to change the resident and both LVNs left the room. CNA 1 was aggressive and forceful when handling Resident B and was not using proper body mechanics when turning Resident B. A review of CNA 1's written statement, dated May 26, 2025, indicated, .went to room [number] found the patient was very wet and shitty I let him know that I'm going to clean him and he said no I don't want to be clean .started to clean hi [sic] start screaming when the 2 LVNs get there but I did not do anything wrong with him except clean him up. Patient is confuse (sic) . A review of the facility's in-service on abuse, dated May 27, 2025, indicated, .Instances of abuse of all residents, irrespective (regardless of, not taking into account) of any mental or physical condition, can cause physical harm, pain, or mental anguish .all staff are mandated reporters and are required to report all instances of suspected abuse .overly stressed Healthcare Personnel are more likely to be abusive or neglectful. Stress can come with dealing with difficult or aggressive residents .staffing challenges .if staff feel themselves losing their patience, they should ask a co-worker to take over and take a break . A review of the facility's policy titled Identifying Types of Abuse, dated September 2022, indicated, .Abuse of any kind against residents is strictly prohibited .preventing abuse requires staff education, training, and support, and a facility-wide culture of compassion and caring .the willful infliction of injury .with resulting physical harm, pain, or mental anguish .verbal abuse .examples of injuries that could indicate physical abuse .dislocation .neglect includes .indifference to or disregard for resident care, comfort, or safety results in emotional distress .mental abuse is the use of verbal .conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation .verbal abuse includes the use of verbal .communication .to resident within hearing distance .mocking, insulting .depriving a resident of care .derogatory statements directed to the resident .the following situations are recognized as those that are likely to cause psychosocial harm which may take months or years to manifest .any staff to resident physical .mental/verbal abuse .when facility staff .withhold care from the resident . A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation -Report and Investigation, dated September 2022, indicated, .Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is completed .If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated . A review of the facility's policy titled Investigation Injuries, dated December 2016, indicated, .a designee will assess all injuries and document clinical findings in the clinical record .If an incident/accident is suspected, a nurse or nurse supervisor will complete a facility-approved accident/incident form .documentation shall include information relevant to risk factors and conditions that could cause or predispose someone to similar signs and symptoms .who have had contact with the resident during the past 48 hours. The investigation will follow the protocols set forth in our facility's established abuse investigation guidelines . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Activities of Daily Living (ADL), Supporting, dated March 2018, indicated, .Appropriate care and services will be provided for residents .in accordance with the plan of care, including appropriate support and assistance with hygiene .elimination .if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate .

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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 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 allegation of abuse by a Certified Nursing Assistant (CNA) was reported to the California Department of Public Health (CDPH - a State Agency [SA]) immediately or within two hours according to the facility policy and procedure, for one of four residents (Resident B). This failure had the potential to result in the delay in the investigation of the allegation of abuse and could further expose the vulnerable residents from further abuse. Findings: On June 11, 2025, at 9:50 a.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse. On June 11, 2025, at 10 a.m., an interview was conducted with the Administrator (Admin). The Admin stated on the morning of May 26, 2025, he had received a call from Licensed Vocational Nurse (LVN) 1, regarding CNA 1 was being rough while providing care to Resident B. The Admin stated LVN 1 asked him how to fill out the abuse paperwork, he went over the procedure with LVN 1, including step by step guide to fill the form out and who to notify. The Admin stated when he came in the following morning on May 27. 2025, he noted LVN 1 did not notify CDPH about the allegation of abuse. On June 11, 2025, at 10:30 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated an abuse allegation was reported to them by LVN 1 that CNA 1 was aggressively providing care to Resident B on May 26, 2025. The ADON stated the abuse allegation should have been reported to CDPH within two hours from the time the facility was made aware of the abuse allegation. On June 11, 2025, at 11:30 a.m., a follow up interview was conducted with the Admin. The Admin stated he spoke with LVN 1 on May 26, 2025, around 8 a.m. The Admin stated LVN 1 told him she would take care of the reporting. The Admin stated the next morning, on May 27, 2025, he realized LVN 1 did not send the SOC 341 form out and LVN 1 did not contact CDPH to notify of the abuse allegation. The Admin stated he notified CDPH the abuse allegation on May 27, 2025. On June 11, 2025, at 12:30 p.m., a review of Resident B's medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (nerve cell damage in the brain that affects movement, includes tremors), dementia (a group of conditions with impairment of brain function, memory loss and judgement). A review of Resident B's History and Physical, dated May 24, 2025, indicated, .Patient is frail, confused, and slow. Dementia impacts is ability to make independent decisions .Requires moderate to maximum assistance for bed mobility . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident B's Progress Notes, dated 9 a.m., indicated, .around 0720 (7:20 a.m.) resident was screaming in (room number) LVN (name of LVN) and I ran to see wat (sic) happened and saw cna (name of CNA) changing resident very aggressively pushed resident to the side pulled sheet out form (sic) under him using force stating he's all shitty know (sic) one changed him did not acknowledge resident at all resident continues to scream he hurt me. Approached Ccna to please be more gentle with patient yeall at me he was being combative resident was not being combative upon my observation .reported to RN (Registered Nurse name) on duty, she proceeded to call ADON (Assistant Director of Nursing) .spoke with Administrator explained to send cna (CNA) home suspended, get statement, notify family, notify MD (physician) .fax over soc 341 to ombudsman . A review of the facility's document titled Investigation Check-list for Alleged Abuse, indicated, .Licensing Agency (CDPH) notification timelines .within 2 (two) hours, if resulted in serious bodily injury; within 24 hours, if not resulted in serious bodily injury . On June 13, 2025, at 8:20 a.m., during an interview with LVN 1, she stated they were two CNAs short and CNA 1 was upset about it. LVN 1 stated she and another LVN were at the nurse's station and heard screaming from coming from the resident's room. LVN 1 stated she observed CNA 1 was pushing and pulling on Resident B while the resident was yelling he hurt me. LVN 1 stated CNA 1 was attempting to clean Resident B and the resident was on his right side and CNA 1 pulled the draw sheet out from under the resident and stated he is f****** shitty. LVN 1 stated CNA 1 was aggressive and forceful when handling the resident and did not use proper body mechanics while cleaning up Resident B. LVN 1 stated the abuse binder was not complete so she was not able to complete all the documents and procedure needed to be done for the abuse allegation on May 26, 2025. A review of the State and Federal Mandated Reporting Guidelines in Long-Term Care Facilities, indicated, . Written report or SOC 341 refers to the state form for reporting elder and dependent adult abuse .'Serious bodily injury': an injury involving extreme physical pain . A review of the Elder Justice Act (EJA) (Skilled Nursing Facilities-Federal Law), indicated, .all instances of suspected crimes committed against residents or others receiving care in long-term health care facilities . must be reported, by the facility to at least local law enforcement agency and to the licensing and certification program of the California Department of public health .events that result in serious bodily injury shall be reported immediately, but no later than 2 (two) hours after forming the suspicion, and all other reports within 24-hours . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Report and Investigation, dated September 2022, indicated, .All reports of abuse .are reported to local, state, and federal agencies .If resident abuse or injury of unknown source is suspected, the suspicion must be reported immediately, to the administrator and to other officials according to state law .the individual making the allegation immediately reports .suspicion to .the state/licensing/certification agency responsible for surveying/licensing the facility .within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .the administrator is responsible for determining what actions .are needed for the protection of residents .All allegations are thoroughly investigated .the administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility .Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is completed .If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated .