

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026
NAME OF PROVIDER OR SUPPLIER Murrieta Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1) was discharged to a facility that would be able to provide the care required by the resident. Resident 1 was discharged to an assisted living facility (ALF- a residential community providing housing, meals, and personalized support for older adults or people with disabilities who need help with daily activities [ADLs- activity of daily living] but not round the clock skilled nursing [high level medical care requiring the expertise of licensed professionals like registered nurses, licensed vocational nurses, and therapist]), which was unaware of the presence of the unstageable pressure injury (a full thickness skin and tissue loss where the actual depth of the wound is completely obscured by slough [soft, yellowish, stringy, dead tissue] or eschar) on the right heel. This failure resulted in Resident 1 being transferred to a general acute care hospital (GACH), on the day Resident 1 was discharged from the skilled nursing facility (SNF) to the ALF, due to inability to provide the required care and services for Resident 1's pressure injury. Findings: On January 8, 2026, at 11:14 a.m., an unannounced visit to the facility on a complaint investigation was initiated. A review of Resident 1's face sheet indicated resident was admitted on [DATE], with diagnoses of pressure ulcer of right heel, unstageable; type 2 diabetes mellitus (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), wedge compression fracture of first lumbar vertebra (a common spinal injury where the front portion of the vertebral body collapses due to excessive force, while the back remains intact). A review of Resident 1's History and Physical, dated October 27, 2025, indicated resident was alert and oriented X (times) 3 (oriented to person, time, and place). On January 8, 2026, at 12:22 p.m., an interview was conducted with the SNF Case Manager (CM). The CM stated that Resident 1 was to be discharged to an ALF with home health, physical therapy, and wound care. On January 8, 2026, at 1:49 p.m., an interview was conducted with the Treatment Nurse (TN 2). TN 2 stated that Resident 1 was admitted on [DATE], with a right heel unstageable wound, also described as a diabetic foot ulcer (DFU - an open, full-thickness wound or sore, typically located on the bottom of the foot, that occurs in individuals with diabetes). TN 2 stated that Resident 1 received daily wound cleansing with povidone-iodine (a stable chemical complex acting as a powerful, broad-spectrum topical antiseptic), and dressing changes. On January 8, 2026, at 4:45 p.m., an interview and record review was conducted with the CM. The CM confirmed that form 602 (a mandatory physician's report for seniors moving into state-licensed residential care facilities completed by a doctor to detail a resident's medical, mental, and physical capabilities, TB test results, and care needs) was completed on November 3, 2025, indicating, .Physical Health Status.m. History of Skin Condition or Breakdown was checked Yes R [right] heel w/o pressure injury was handwritten. The CM was unsure of the w/o abbreviation. The CM also confirmed</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555747
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>this information was emailed to the ALF on December 18, 2025. On January 9, 2026, at 11:24 a.m., an interview and record review was conducted with the Registered Nurse (RN). The RN stated that discharge instructions should include the discharge location and documentation of any wounds. The RN confirmed that Resident 1's Discharge Instruction Form / Recapitulation of Stay V-2 dated December 22, 2025, indicated a discharge to a private residence but did not document Resident 1's right heel wound. On January 9, 2026, at 12:24 p.m., a telephone interview was conducted with the ALF Resident Service Director (RSD). The RSD stated that the ALF Executive Director visited the SNF to assess Resident 1. At the time, the right heel pressure injury had a dressing and the Executive Director did not see the extent of the pressure injury and the facility staff reported the wound was healing. The RSD stated the 602-form signed by the Nurse Practitioner indicated no pressure injury, however; on December 22, 2025, upon admission to the ALF, the facility assessed the resident's right heel wound as unstageable and the resident had to be transferred to the GACH due to their inability to care for it. On January 9, 2026, at 1:08 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated that usually the ALF would determine if the resident is appropriate for their facility. The SSD stated that an ALF can take a simple wound and typically do not take an unstageable wound. On January 9, 2026, at 2:03 p.m., a telephone interview was conducted with the Nurse Practitioner (NP). The NP stated that she recalled Resident 1 with a right heel wound. When the NP was asked about the w/o abbreviation and the NP confirmed the abbreviation meant without. The NP stated that she was unable to recall what kind of wound was present on the right heel and was unable to recall why she documented Resident 1's right heel as without pressure injury. The NP stated that Resident 1 was discharged from the skilled nursing facility to the ALF and was transferred to the GACH because the ALF could not manage the wound. A record review of Resident 1's Wound Assessment dated December 16, 2025, (six days prior to discharge to ALF), indicated .Wound type. Diabetic. Discussion/Relevant Interim History. RE-EVAL-R HEEL. Location R HEEL Post (cm) [centimeters] L [length] ulcer] . Prognosis . Non-Healable . Negative Progression . Additional Devitalized Tissue. Infection. Drainage: None . Odor: None . Wound Bed: .Eschar 100% . Sinus/Tunneling . No .Wound Margins (circle) . Regular .Treatment: Topical: Betadine Frequency: Daily .Evidence of Improvement . ? Stable .A record review of Resident 1's Order Summary Report, dated December 22, 2025, indicated, .Patient request discharge 12/22/25 to [name of ALF and address] w/ [with] Home Health nursing for evaluation and medication management/ PT [physical therapy] evaluation and treatment/ Wounds Care: Betadine 3.6 W [width] 3.1 D [depth] UTD [unable to determine] Wound Type DFU [diabetic foot Swab sticks 10% apply to right heel topically every day for pressure injury, cleanse with NS [normal saline], pat dry W/ [with] 4 X 4 gauze, paint with swab. A review of the facility policy and procedure titled, Discharge Summary and Plan, revised October 2022, indicated, When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge .1. The discharge summary includes recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's .course of illness, treatment and/or therapy since entering the facility .medication therapy .3. Every resident is evaluated for his or her discharge needs and has an individualized post-discharged plan .The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge .</p>		