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	03/25/2026

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 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 care and treatment was provided, for one of four residents reviewed (Resident 1), when the resident's left great toe skin condition was not evaluated and referred to the physician for further treatment.This failure resulted in a delay in the care and treatment of Resident 1's skin condition and had a potential risk for further complications such as infection.Findings:On February 25, 2026, at 11:35 a.m., an unannounced visit was conducted at the facility to investigate complaints on quality of care.On February 25, 2026, at 2:16 p.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 1 complained of her feet hurting while she and CNA 2 were pulling up Resident 1 in bed on February 10, 2026. CNA 1 stated they removed her socks and saw a blister (a painful skin condition where fluid fills a space between layers of skin) on Resident 1's left great toe, with the skin slightly lifted and was pink underneath, but was not bleeding nor weeping (having secretions). CNA 1 stated she notified the Treatment Nurse (TN), stating to the TN that (Resident 1's nickname) had a blister on her left great toe, to which the TN replied, I'm doing rounds anyway. CNA 1 further stated when she returned to work two days later, she received no report or update that anything was done about the blister from the time she reported it to the TN, and when Resident 1's daughter reported it to the charge nurse, she recalled she had already reported it to the TN a couple of days prior.On February 26, 2026, at12:08 p.m., Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar), morbid obesity (severe obesity), and dementia (decline in cognitive function-memory, language, problem-solving, and thinking, severe enough to interfere with daily life).A review of Resident 1's Minimum Data Set (MDS - a clinical assessment tool), indicated Resident 1 had memory problems and cognitive difficulty in new situations.A review of Resident 1's Order Summary Report, included physician's orders to send Resident 1 out to the ER (emergency room) for evaluation of left foot with green and red discoloration and skin tear and build up of skin debris, date ordered February 14, 2026. A review of Resident 1's eINTERACT Change in Condition Evaluation, dated February 14, 2026, indicated, .change in condition is .skin wound or ulcer.things that make the condition or symptoms unchanged.lack of treatment.Summary.Family approached nursing station and asked about skin concerns to LT (left) foot. Entered residents (sic) room and noted LT foot with green and red skin discoloration to great LT toe and top of LT foot with skin tear and build up of skin debris Further review of Resident 1's record There was no indication the wound on Resident 1's left big toe was assessed and referred to the physician for appropriate treatment when it was first identified by CNA 1 and reported to the TN on February 10, 2026.A review of resident 1's care plans indicated there was no documented evidence a care plan was developed to address the left foot wound.On February 26, 2026, at 12:58 p.m. CNA 2 was interviewed. CNA 2 stated she assisted CNA 1 to pull Resident 1 up in bed and Resident 1 had complained of pain on her left foot, in the beginning of February. CNA 2 stated CNA 1 took of the sock and realized the wound was there, it was not open yet and it as dry and flakey. CNA 2 stated CNA 1 told Resident 1 she was going to notify the TN, and CNA 1 left Resident 1's sock off to air dry the foot, and because the socks were hurting the foot.On February 26, 2026, at 1:24 p.m., the Licensed Vocational Nurse was interviewed. The LVN (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated in the evening of February 14, 2026, Resident 44's family member (FM) went up to the nurses' station really upset about the wound on Resident 44's foot that she was not aware of at that time. The LVN stated she took pictures of the foot to send to the doctor and advised Resident 44's FM she was going to check if anything had been ordered for it. The LVN stated she did not see any treatment orders for the left foot skin condition. The LVN stated there were three specific areas where there was excess skin debris that were green in color, and the top of the foot was flakey. Additionally, Resident 1's toenail was really concerning since the bed was reddened; the lateral (side) part of the foot looked like a wound with blackened area and she could not tell if it was dried blood or a scab; and the entire left great toe was flakey and had greenish skin debris. The LVN also stated the FM told her it was extending under the toes, and as the LVN raised Resident 1's toes, the FM tried to grab some skin debris and the LVN stopped the FM from doing. The LVN stated it was extending between the left great toe and 2nd toe along the web of the foot. The LVN stated there was no prior communication to her about the skin condition and there was no documentation about it in Resident 1's chart. The LVN stated after the physician was notified and gave orders, Resident 1 was sent out to the GACH ER for evaluation of the wound.A review of the Director of Nursing's (DON) interview notes, dated February 15, 2026, indicated an interview with the TN. The document indicated the TN last evaluated Resident 1's foot two weeks prior, Resident 1 had an on and off issue with dryness and flakiness, which was treated with A & D ointment (Vitamin A and D topical application), and the wound care nurse practitioner did not round on Resident 1 because the skin condition was related to diabetes and vascular (related to blood vessels) issues.On February 26, 2026, at 2:46 p.m., the DON was interviewed. The DON stated she was notified by the LVN of the FM's complaint about Resident 1's left foot. The DON stated she investigated the matter and found out that CNA 1 notified the TN prior to February 14, 2026. The DON stated during her interview with the TN on February 15, 2026, the TN stated she evaluated the wound 2 weeks prior, was using wound wash on the wound and patting it dry, and applied A & D ointment, and the treatments were supposed to be daily or twice a week. The DON stated the TN was doing re-evaluations every 21 days, and the re-assessment of the site and re-evaluation of the treatment orders should have been done at that time. The DON stated during a follow up interview with the TN on February 16, 2026, she discussed with the TN how the prompt appeared on Resident 1's electronic medical records for a wound re-evaluation. The DON stated when she asked the TN if she should have done a re-evaluation, the TN stated, I've been doing it for 20 yrs, I have it in my memory.A review of the facility's policy and procedure titled, Resident Examination and Assessment, dated February 2014, indicated, .The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan.Skin.intactness.moisture.color.texture.and.presence of bruises, pressure sores, redness, edema, rashes.Notify the physician of any abnormalities sch as, but not limited to.wounds or rashes on the resident's skin. Report all other information in accordance with facility policy and professional standards of practice.A review of the facility's policy and procedure titled, Change in a Residents' Condition or Status, revised February 2021, indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.The nurse will notify the resident's attending physician or physician on call when there has been a(an).significant change in the resident's physical/emotional/mental condition.need to transfer the resident to a hospital/treatment center.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.