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	03/05/2026

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

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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 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. Based on observation, interview, and facility record review, the facility failed to ensure the sanitary requirements were met in the kitchen when: -An opened bag of frozen ground meat had an opened date of 7/11/24.-An opened container of Italian seasoning had a use-by date of 2/25/26.-The wire racks in the walk-in refrigerator were observed with dust.-A table-mounted can opener was observed with a brown sticky substance.-A pizza cutter was observed with crusty debris.-Five clear plastic bowls, five metal baking trays, and three plastic storage containers were stored and stacked on top of each other while still wet.These failures had the potential to expose 131 of 132 highly susceptible residents who received food from the kitchen to food borne illnesses (any illness resulting from eating contaminated/spoiled foods) due to cross-contamination (the transfer of harmful substances or disease-causing microorganisms to food). Findings: 1. During a concurrent observation and interview on 3/2/26 at 7:48 AM with Dietary Aide (DA) 1 during the initial tour, the following items were observed:-An opened, unlabeled, and undated bag of frozen ground meat was found in a box labeled Casa Solana Carne de Chorizo Sausage Bulk with an open date of 7/11/24 in the walk-in freezer.-An opened container of Italian seasoning had a use-by date of 2/25/26.DA 1 verified the findings and stated the food items should have been thrown away to prevent food borne illness and cross-contamination.A review of the facility's policy and procedure titled, Food Receiving and Storage, revised November 2022, indicated .Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. Dry foods that are stored in bins are removed from original packaging, labeled and dated (?use by' date). All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated food are labeled, dated and monitored so they are used by their ?use-by' date, frozen, or discarded.2. During a concurrent observation and interview on 3/2/26 at 7:48 AM with DA 1, during the initial tour, the following items were observed:-Five clear plastic bowls were stored and stacked on top of each other while still wet.-The wire racks in the walk-in refrigerator were observed with dust.-A table-mounted can opener was observed with a brown sticky substance.-A pizza cutter was observed with crusty debris.-Five metal baking trays were stored and stacked on top of each other while still wet.3. During an observation and interview on 3/2/26 at 8:30 AM with the Director of Dietary Services (DDS), the following items were observed:-Three plastic food storage containers were stored and stacked on top of each other while still wet.The DDS verified the above findings and stated the food equipment should have been properly cleaned, sanitized, and completely dried before storing to prevent cross-contamination and food related illnesses.A review of the 2022 United States (U.S.) Food Code, Section 4-601.11 .Equipment, Food-Contact Surfaces, Nonfood-Contact Surface, and Utensils, indicated .the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris .A review of the 2022 U.S. Food Code, Section 4-602.13 .Nonfood-Contact Surfaces, indicated nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.A review of the 2022 U.S. Food Code, Section 4-901.11 Equipment and Utensils, Air- Drying Required, indicated .items (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility record review, the facility failed to ensure the residents' food brought by visitors were properly labeled and stored in the refrigerator. This failure had the potential to expose highly susceptible residents who stored their foods in the unit refrigerator to foodborne illnesses (any illness resulting from eating contaminated/spoiled foods) due to cross-contamination (the transfer of harmful substances or disease- causing microorganisms to food). Findings:During a concurrent observation and interview on 3/2/26 at 8:52 AM with the Assistant Director of Nursing (ADON), the following were observed in the resident refrigerators:-One jar of Mango Thokku (grated pickled mango) was unlabeled and undated.-One Ziplock bag of dough-like food item with brown chunks on top was unlabeled and undated.-One frozen Starbucks drink was unlabeled and undated.-One bag of frozen tamales was unlabeled and undated.-Two beverages containers containing brown liquid were unlabeled and undated.The ADON stated all foods placed in the resident refrigerators should be labeled and dated prior to being stored to prevent food-borne illnesses.A review of the facility's policy and procedure titled Food Receiving and Storage, revised November 2022, indicated .All foods belonging to residents are labeled with the resident's name, the item and the ?use by' date. Beverages are dated when opened and discarded after twenty-four (24) hours .Other opened containers are dated and sealed or covered during storage .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and facility record review, the facility failed to dispose and store trash in a sanitary manner.This failure had the potential to increase the risk of pest infestation in the facility.Findings:During a concurrent observation and interview on 3/2/26 at 3:24 PM with Dietary Aide (DA) 3, four of the five outdoor garbage dumpsters were observed uncovered. DA 3 stated the dumpsters should be kept closed. During a follow up interview on 3/2/26 at 3:50 PM with the Director of Dietary Services (DDS), the DDS stated the garbage dumpsters should be kept covered to prevent attracting pests, which may spread illness and disease. A review of the 2022 United States (U.S.) Food Code, Section 5-501.113 Covering Receptacles, indicated Receptables and waste handling units for refuse, recyclables and returnables, shall be kept covered:. (B) With tight fitting lids or doors if kept outside the food establishment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and professional standards of practice when a medication error rate of 8.62% was identified, with five medication errors out of 58 medication administration opportunities, during medication administration observations for four of eight residents observed (Residents 38, 148, 168, and 169).These failures included administration of medications in inappropriate dosage forms, improper medication administration technique inconsistent with professional standards, and administration of medications outside physician-ordered parameters, which had the potential to compromise medication effectiveness, increase the risk of adverse drug effects, and result in potential adverse clinical outcomes including gastrointestinal (stomach and intestine) irritation, infection (such as oral thrush), and compromised medication therapy and resident safety.Findings: 1. During a medication administration observation for Resident 169 on 3/2/26 at 8:22 AM, Licensed Vocational Nurse (LVN) 3 prepared 12 oral medications by crushing nine tablets and opening three capsules and mixing them with chocolate pudding. The prepared pudding mixture included the following:- Potassium chloride (supplement) extended-release (ER - a medication formulation designed to release the drug slowly over an extended period) 20 milliequivalent (mEq - a unit of measurement) tablet. LVN 3 crushed the tablet and mixed it with other medications in chocolate pudding; and- Aspirin (used to prevent blood clots) enteric-coated (EC - a coating on the drug tablet to protect the stomach and to allow aspirin to pass through the stomach to the small intestine before dissolving) 81 milligram (mg - a unit of measurement) tablet. LVN 3 placed the whole tablet into the pudding mixture with other crushed medications.During a concurrent observation on 3/2/26 at 8:33 AM, LVN 3 administered the pudding mixture to Resident 169 by the spoonful. LVN 3 provided three spoonfuls of the mixture. Resident 169 chewed each spoonful before swallowing. The pudding mixture contained the aspirin enteric-coated tablet.A review of Resident 169's physician orders indicated the following orders:- Potassium chloride extended-release 20 mEq, Give 1 tablet by mouth one time a day for Supplement, dated 2/25/26.- Aspirin delayed-release 81 mg, Give 1 tablet by mouth one time a day for clot ppx (prophylaxis - prevention) . dated 2/24/26.During a concurrent interview and record review on 3/3/26 at 10:17 AM with LVN 3, LVN 3 acknowledged the aspirin EC tablet could be chewed when mixed with pudding unless the resident was instructed to swallow it whole. LVN 3 stated she should have notified the physician to consider changing the order to a chewable aspirin or administer the aspirin EC tablet separately with water. LVN 3 also acknowledged the potassium chloride ER tablet should not have been crushed and stated crushing the tablet could cause the medication to be released immediately rather than slowly.During a concurrent interview on 3/3/26 at 4:22 PM with the Director of Nursing (DON), the DON stated nursing staff should have contacted the pharmacy to identify alternative formulations and notified the physician to obtain an appropriate order rather than crushing the extended-release potassium tablet and adding the aspirin EC tablet with the pudding.2. During a medication administration observation for Resident 38 on 3/2/26 at 8:38 AM, LVN 3 prepared five oral medications including potassium chloride ER 20 mEq tablet.During a concurrent observation on 3/2/26 at 8:49 AM, LVN 3 crushed the potassium chloride ER tablet with other medications and mixed the crushed medications with chocolate pudding.During a concurrent observation on 3/2/26 at 8:50 AM, LVN 3 administered the pudding mixture containing the crushed medications to Resident 38.A review of Resident 38's physician order, dated 9/1/23, indicated Potassium Oral Tablet (Potassium) 20 mEq .Give by mouth one time a day for supplement .Give with 8 oz (ounce - a unit of measurement) water.During a concurrent interview on 3/3/26 at 10:20 AM with LVN 3, LVN 3 confirmed the potassium chloride ER tablet was crushed and mixed with pudding. LVN 3 acknowledged she should not have crushed the medication and stated crushing the tablet could cause the medication to be released immediately rather than slowly over time.During a concurrent interview on 3/3/26 at 4:22 PM with the DON, the DON stated nursing staff should have (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contacted the pharmacy for alternative formulations and notified the physician to obtain an appropriate order rather than crushing the extended-release potassium tablet.A review of the manufacturer's package inserts (document included in the package of a medication with information about drug and its use) for potassium chloride ER tablets indicated .To take each dose without crushing, chewing or sucking the tablets. If those patients are having difficulty swallowing whole tablets, they may try one of the following alternate methods of administration: a. Break the tablet in half and take each half separately with a glass of water. b. Prepare an aqueous (water) suspension as follows: 1. Place the whole tablet(s) in approximately 1/2 glass of water (4 fluid ounces). 2. Allow approximately 2 minutes for the tablet(s) to disintegrate. 3. Stir for about half a minute after the tablet(s) has disintegrated. 4. Swirl the suspension and consume the entire contents of the glass immediately by drinking or by the use of a straw. 5. Add another one fluid ounce of water, swirl, and consume immediately. 6. Then, add an additional one fluid ounce of water, swirl, and consume immediately.3. During a medication administration observation on 3/2/26 at 9:05 AM, LVN 3 prepared 14 medications for Resident 148, including Pulmicort (budesonide inhalation powder, an inhaled corticosteroid used to reduce airway inflammation) Flexhaler (a breath-activated dry powder inhaler that releases medication when the resident inhales through the mouthpiece) 90 microgram (mcg - a unit of measurement), and Anoro Ellipta inhaler (a combination inhalation medication containing umeclidinium and vilanterol used to treat chronic obstructive pulmonary disease ([COPD], a lung disease causing difficulty breathing) 62.5 mcg/25 mcg.During a concurrent observation on 3/2/26 at 9:19 AM, Resident 148 self-administered one puff of Anoro Ellipta followed by one puff of Pulmicort. Immediately afterward, LVN 3 handed the resident oral medications with water, and the resident swallowed the medications without rinsing the mouth.A review of Resident 148's physician order, dated 2/1/26, indicated Pulmicort Flexhaler 90 mcg per actuation (one inhalation dose released from the inhaler when activated), 1 puff inhale orally every 12 hours for COPD [chronic obstructive pulmonary disease - a progressive lung disease which blocks air flow making breathing difficult].During a concurrent interview and record review on 3/3/26 at 10:26 AM with LVN 3, LVN 3 confirmed Resident 148 did not rinse the mouth and spit after the Pulmicort inhalation. LVN 3 stated she previously explained to Resident 148 that rinsing the mouth and spitting after inhalation of Pulmicort helped prevent oral thrush infection. LVN 3 acknowledged she did not document the refusal or notified the physician for further instruction.During a concurrent interview on 3/3/26 at 4:25 PM, the DON stated the manufacturer's instructions for Pulmicort should be followed, and nursing staff should notify the physician because a resident refusal required further administration steps.A review of the manufacturer's package inserts for Pulmicort Flexhaler, dated 7/2025, indicated .After inhalation, the patient should rinse the mouth with water without swallowing.Warnings and Precautions.In clinical studies, the development of localized infections of the mouth and pharynx with Candida albicans has occurred in patients treated with PULMICORT FLEXHALER.Patients should rinse the mouth after inhalation of PULMICORT FLEXHALER. 4. During a medication administration observation on 3/2/26 at 9:33 AM, LVN 5 asked Resident 168 what pain level the resident was currently experiencing. Resident 168 stated the pain level was 3 (mild pain, on a 0-10 pain scale, where 0 indicates no pain and 10 indicates severe pain) and requested stronger medication before the scheduled physical therapy. LVN 5 prepared and administered oxycodone-acetaminophen 5-325 mg (generic for Percocet, a narcotic pain medication used to treat moderate to severe pain) to Resident 168.During a record review on 3/2/26 at 3:43 PM, Resident 168's physician orders indicated the following orders on 2/19/26:-Oxycodone-acetaminophen 5-325 mg, Give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) .-Acetaminophen (pain medication) 325 mg, Give 1 tablet by mouth every 4 hours as needed for mild pain 1-3 .A review of Resident 168's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for March 2026, indicated Resident 168's pain level was documented as 3 prior to the administration of Percocet on 3/2/26.During an interview on 3/2/26 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 4:15 PM with LVN 5, LVN 5 stated Resident 168 refused acetaminophen and requested a stronger pain medication prior to physical therapy. LVN 5 further stated she wrote made a progress note documenting the resident's request.During a concurrent interview and record review on 3/3/26 at 12:51 PM with LVN 5, LVN 5 acknowledged the physician's order was not followed and stated she should have reassessed the resident's pain and notified the physician for clarification of the order.During a concurrent interview on 3/3/26 at 4:30 PM with the DON, the DON confirmed the Percocet was administered when the resident's documented pain level was 3 and stated nursing staff should follow physician-ordered pain parameters or contact the physician for clarification.A review of the facility's policy and procedures titled Administering Medications, dated April 2019, indicated .Medications are administered in accordance with prescriber orders.If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident.the person preparing or administering the mediation will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.The individual administering the medication checks he label THREE (3) times to verify.right medication, right dosage.before giving the medication.

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	555747	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:The Maintenance Assistant (MA) did not perform hand hygiene before entering and after leaving a room on Enhanced Barrier Precautions ([EBP] - an infection control prevention designed to reduce the transmission of multi-drug-resistant organisms (MDROs) in healthcare settings, particularly nursing homes).An Activity Assistant (AA) did not perform hand hygiene before entering and after leaving a room on EBP.A Physical Therapy Assistant (PTA) did not perform hand hygiene and did not wear proper personal protective equipment ([PPE] - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) before and after providing care to Resident 46, who was on EBP.Resident 46's respiratory supplies had no label.Resident 74's respiratory supplies had no label.A Licensed Vocational Nurse (LVN) 3 did not clean and disinfect shared medical equipment, blood pressure (BP - the force of blood pushing against the walls of the blood vessels as the heart pumps) cuff (a reusable inflatable medical device placed around the arm to measure blood pressure), stethoscope (a medical listening device used to listen to sounds inside the body), and pulse oximeter (a reusable finger device placed on the finger to measure the pulse rate and oxygen level in the blood) between each use for Residents 38, 148, and 169, in accordance with the facility's infection control policy.These failures had the potential for cross-contamination and spread of infection which can adversely affect the health and wellbeing of 132 medically compromised residents. 1. During an observation on 3/2/26 at 9:19 AM, room [ROOM NUMBER] had a signage posted next to the entry door that indicated, STOP .ENHANCED BARRIER PRECAUTIONS .EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing,/Showering, Transferring . During an observation on 3/2/26 at 9:21 AM, in the hallway of station 4, the MA entered and left room [ROOM NUMBER] without performing any hand hygiene. During an interview on 3/2/26 at 9:25 AM with the MA, the MA acknowledged he did not perform hand hygiene before entering and after leaving the room. He also stated that it was important to wash hands or perform hand hygiene to prevent the spread of germs to staff and other people. 2. During an observation on 3/2/26 at 9:31 AM, room [ROOM NUMBER] had a signage posted next to the entry door that indicated, STOP .ENHANCED BARRIER PRECAUTIONS .EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring . During a concurrent observation and interview on 3/2/26 at 9:32 AM, in the hallway of station 4, the AA was observed distributing the The Daily Chronicles (a daily record of events) to residents inside the room. The AA entered and left room [ROOM NUMBER] without performing any hand hygiene. The AA acknowledged that there was an EBP signage posted and that the expectations were for staff to follow them. The AA stated that it was important to follow precautions to prevent the spread of germs and protect staff and residents. During an interview on 3/4/26 at 4:02 PM with the Infection Preventionist (IP), the IP stated staff were expected to follow EBP and emphasized that staff should perform hand hygiene before entering and after leaving the resident's room, whether they were on EBP or not. She added that it was (continued on next page)

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	555747	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unacceptable for staff not to practice hand hygiene, as it was a standard precaution. The IP stated that it was very important to prevent the spread of infection. During an interview on 3/4/26 at 4:17 PM with the Registered Nurse (RN) 1, RN 1 stated that the staff was expected to follow EBP and use the proper PPE. RN 1 added that these were important to prevent the transmission of infections. 3. During an observation on 3/5/26 at 8:46 AM, room [ROOM NUMBER] had a signage posted next to the entry door that indicated, STOP .ENHANCED BARRIER PRECAUTIONS .EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing,/Showering, Transferring . During an observation on 3/5/26 at 8:48 AM, in front of room [ROOM NUMBER], the PTA entered the room and donned gloves without performing hand hygiene. The PTA put on Resident 164's socks and gait belt and then assisted the resident to transfer from the bed to the walker without wearing a gown. The PTA then removed her gloves and left the room with the resident without performing any hand hygiene. During an interview on 3/5/26 at 8:52 AM with the PTA, the PTA acknowledged that she should have performed hand hygiene and worn gown while providing care to the resident. During a concurrent interview and record review on 3/5/26 at 11:34 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene, revised October 2023, Enhanced Barrier Precautions dated August 2022 and Policies and Practices-Infection Control revised April 2025 were reviewed. The DON stated that the staff was expected to wear the proper PPE and follow EBP. The DON verified that based on the observations made by the surveyor, the facility did not follow its P&P. A review of the facility's P&P titled Handwashing/Hand Hygiene, revised October 2023, indicated .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Administrative Practices to Promote Hand Hygiene.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. Immediately before touching a resident;.d. after touching a resident; e. after touching the resident's environment; .g. immediately after glove removal.5. The use of gloves does not replace hand washing/hand hygiene.Procedure: Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. A review of the facility's P&P titled Enhanced Barrier Precautions, dated August 2022, indicated . Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents .Policy Interpretation and Implementation .2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing.c. transferring.6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Policies and Practices- Infection Control, revised April 2025, indicated . This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation: 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors.2. The objectives of our infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility;.c. establish guidelines for implementing isolation precautions, including standard and transmission-based precautions. 4. During an initial tour observation on 3/2/26 at 8:35 AM, inside room [ROOM NUMBER], a plastic respiratory bag containing nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing, nebulizer mask (a flexible respiratory supply, covering both the nose and mouth used to deliver liquid medication directly into the lungs as a fine mist), and nebulizer tubing were observed at resident's bedside. All the respiratory supplies and bag had no label. During a concurrent observation and interview on 3/2/26 at 8:55 AM, inside room [ROOM NUMBER], Licensed Vocational Nurse (LVN) 1 stated that Resident 46 was out of the facility for an appointment. LVN 1 acknowledged that the respiratory bag was unlabeled, and the nasal cannula, nebulizer mask, and tubing were also undated. LVN 1 stated that the expectations were for these supplies to be changed at least weekly and should be labeled with resident's name and date. A review of Resident 46's admission Record, (a document showing a summary of the resident's information), dated 3/5/26, indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic congestive heart failure ([CHF] -a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), pneumonia (an infection/inflammation in the lungs), and resistance to multiple antimicrobial drugs (antibiotics). A review of Resident 46's Order Summary Report, dated 3/5/26, indicated Resident 46 had the following orders: -Change Oxygen Nasal Cannula Q [every] wk [week] on Wednesday and PRN [as needed] (with name and date label) every night shift every Wed.-Oxygen at 2liter/min via Nasal Cannula continuously every shift.-IPRAT-ALBUT (Ipratropium- Albuterol) 0.5-3 (2.5) MG [(mg) - metric unit of measurement, used for medication dosage and/or amount) /3 ML ([ml] - metric unit of measurement for volume of a liquid) 1 vial inhale orally via nebulizer four times a day for SOB [shortness of breath]. During an interview on 3/4/26 at 12:33 PM with RN 1, RN 1 stated that respiratory supplies needed to be changed weekly, on Wednesdays. RN 1 also stated that staff were expected to label these supplies with the resident's name, date, and time. RN1 added that it was unacceptable to change and not label them as it was the facility's policy. RN 1 stated it was important for staff to know when the supplies were last changed, how long they were used, and when they needed to be changed. During an interview on 3/4/26 at 3:56 PM with the IP, the IP stated staff were expected to change and label respiratory supplies every week on Wednesdays. The IP added these were important for infection control and it was a respiratory care standard. During an interview on 3/5/26 at 11:41 AM with the DON, the DON stated she expected the staff to label the respiratory bag with the resident's name and date. The DON also added that the nasal cannula and nebulizer tubing should be labeled as well. The DON further stated that it was (continued on next page)

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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unacceptable to leave these respiratory supplies unlabeled. 5. During an observation on 3/1/26 at 8:58 AM, in Resident 74's room, Resident 74's nasal cannula and humidifier solution container did not have any labels or dates on them. During a concurrent observation and interview on 3/1/26 at 9:02 AM with RN 2, in Resident 74's room, RN 2 confirmed the nasal cannula and humidifier solution container were not labeled and dated. During an interview on 3/4/26 at 10:20 AM with the Director of Staff Development (DSD), the DSD stated that the facility taught all nurses to label and date the nasal cannula and humidifier solution containers. During an interview on 3/4/26 at 3:40 PM with the DON, the DON confirmed that the facility's official practice was to label and date all humidifier solutions and nasal cannula tubing. A review of Resident 74's Order Summary Report, dated 3/4/26, indicated Resident 74 had the following orders:-Change O2 humidifier Q Wk_on_WED and PRN when consumed (w/name & date label) every night shift every Wed.-Change Oxygen Nasal Cannula Q Wk on_WED_and PRN (w/name & date label) every night shift every Wed. 6a. During a medication administration observation on 3/2/26 at 8:17 AM for Resident 169, LVN 3 used a BP cuff, stethoscope, and pulse oximeter to obtain Resident 169's blood pressure and pulse in the resident's room. After obtaining Resident 169's blood pressure and pulse, LVN 3 placed the used BP cuff and pulse oximeter on the medication cart surface and placed the stethoscope over the sharps container attached to the side of the medication cart without cleaning or disinfecting the equipment. b. During another medication administration observation on 3/2/26 at 8:38 AM, LVN 3 used the same BP cuff, stethoscope, and pulse oximeter that had not been previously cleaned or disinfected to obtain Resident 38's blood pressure in the resident's room. After obtaining Resident 38's blood pressure and pulse, LVN 3 placed the used BP cuff and stethoscope into the bottom drawer of the medication cart and placed the pulse oximeter into its cover bag located on the medication cart surface, without cleaning or disinfecting the equipment. c. During another medication administration observation on 3/2/26 at 9:05 AM, LVN 3 used the same BP cuff, stethoscope, and pulse oximeter that had not been previously cleaned or disinfected to obtain Resident 148's blood pressure in the resident's room. During an interview on 3/3/26 at 10:26 AM with LVN 3, LVN 3 acknowledged the BP cuff, stethoscope, and pulse oximeter were not cleaned or disinfected between each use for Residents 38, 148, and 169. LVN 3 stated the BP cuff, stethoscope, and pulse oximeter were shared equipment and should have been cleaned and disinfected before and after each use with wipes in the purple cap container (Sani-Cloth germicidal [disinfectant that kills germs such as bacteria and viruses] disposable wipes) available in the medication cart for infection control. During an interview on 3/3/26 at 4:22 PM with the DON, the DON stated any shared medical equipment, including the BP cuff, stethoscope, and pulse oximeter must be cleaned and disinfected (continued on next page)

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	555747	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with disinfectant wipes before and after each use for infection control. A review of the facility's P&P titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, dated September 2022, indicated .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention - a nationally recognized disease control and prevention organization) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration – a government agency for workplace safety) Bloodborne Pathogens (disease-causing germs, like viruses or bacteria in human blood and other body fluids that can cause disease in people) Standard.c. Non-critical items are those that come in contact with intact skin. Non-critical resident-care items include bedpans, blood pressure cuffs.Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturer's instructions. Disinfection is performed with an EPA [Environmental Protection Agency – U.S. federal government agency regulating and approving disinfectants used to kill germs]-registered disinfectant labeled for use in healthcare settings.Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) .

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	555747	A. Building B. Wing	03/05/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information concerning the right to formulate an Advance Directive (a written document specifying an individual's medical care wishes) for three of 26 sampled residents (Residents 3, 7, and 88).This failure could pose significant risks that may negatively affect the residents' quality of life and medical care, leading to medical interventions that do not align with the residents' preferences.Findings:1. A review of Resident 3's admission Record, (a document showing a summary of the resident's information) dated 3/4/26, indicated Resident 3 was readmitted to the facility on [DATE].A review of Resident 3's Physician Orders for Life-Sustaining Treatment, ([POLST] - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated 12/7/23, indicated that Resident 3 had no Advance Directive.A review of Resident 3's medical records revealed no Advanced Healthcare Directive Acknowledgment Form (a form that serves as proof to healthcare providers that the Advance Directive is authentic and valid, allowing them to follow resident wishes regarding medical care, end-of-life decisions, and the appointment of a healthcare agent) was completed.2. A review of Resident 7's admission Record, dated 3/4/26, indicated Resident 7 was readmitted to the facility on [DATE]. A review of Resident 7's POLST, dated 1/12/23, indicated that Resident 7 had no Advance Directive.A review of Resident 7's medical records revealed no Advanced Healthcare Directive Acknowledgment Form.3. A review of Resident 88's admission Record, dated 3/4/26, indicated Resident 88 was readmitted to the facility on [DATE].A review of Resident 88's POLST, dated 10/2/24, indicated that Resident 7 had no Advance Directive.A review of Resident 88's medical records revealed no Advanced Healthcare Directive Acknowledgment Form was completed.During a concurrent interview and record review on 3/3/26 at 10:38 AM, with the Social Services Director (SSD), Residents 3, 7, and 88's medical records were reviewed. The SSD confirmed that there was no Advanced Healthcare Directive Acknowledgment Form provided to the residents or their representatives concerning their rights to formulate an Advance Directive. The SSD stated that the Advanced Healthcare Directive Acknowledgment Form should be completed and discussed with the residents or their family members upon admission.During an interview on 3/4/26 at 4:06 PM, with the Director of Nursing (DON), the DON stated that an Advanced Healthcare Directive Acknowledgment Form should be completed upon admission for all residents. The DON emphasized that the importance of formulating an Advance Directive was to honor the rights and wishes of the residents.A review of the facility's policy and procedure titled Advance Directives, revised September 2022, indicated .The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

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	03/05/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy of the Preadmission Screening and Resident Review ([PASRR] - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level 1 Screening assessment for one of 26 sampled residents (Resident 3).This failure resulted in the missed identification of a serious mental illness that could potentially lead to improper placement or failure to provide appropriate specialized treatment for the resident.Findings:A review of Resident 3's admission Record, (a document showing a summary of the resident's information) dated 3/4/26, indicated Resident 3 was readmitted to the facility on [DATE]. Resident 3's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought).A review of Resident 3's CUSTODIAL CARE Re-admission, dated 10/1/24, indicated Resident 3 was .being treated for an unspecified psychiatric condition with Zyprexa (olanzapine [a medication primarily used to treat schizophrenia]). Under the plan, the document indicated that Resident 3 had unspecified schizophrenia presently managed with medication and indicated continuation of Zyprexa. A review of Resident 3's Order Summary Report, dated 3/5/26, indicated orders for olanzapine 20 milligram ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime for schizophrenia manifested by paranoid delusions (irrational thoughts and beliefs become so fixed that nothing can convince a person that what they think or feel is not true) and to monitor for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) every shift for olanzapine use. A review of Resident 3's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 7/10/24, 6/26/23, and 5/31/23, indicated the answer No for the questions asking whether Resident 3 had a diagnosed serious mental illness such as schizophrenia/schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) or symptoms of psychosis and psychotropic medication (a prescription drug to treat mental health conditions). During a concurrent interview and record review on 3/3/26 at 10:51 AM, with the Minimum Data Set ([MDS] - a standardized assessment tool) Supervisor (MDS-S), Resident 3's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 7/10/24, 6/26/23, and 5/31/23 were reviewed. The MDS-S confirmed that Resident 3's PASRR Level 1 Screenings were not accurately completed. The MDS-S verified that Resident 3 had a serious mental illness and was on psychotropic medication. The MDS-S emphasized the importance of accurate assessment for residents to receive appropriate treatment.During an interview on 3/4/26 at 4:06 PM with the Director of Nursing (DON), the DON stated that residents should be screened for PASRR Level 1 upon admission by the admission staff, and the assessment should be updated as needed by the MDS nurse. The DON confirmed that the PASRR Level 1 Screening should have an accurate assessment to trigger Level 2 Screening when needed.A review of the facility's policy and procedure titled admission Criteria, revised March 2019, indicated .Our facility admits only residents whose medical and nursing care needs can be met. 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.

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	555747	A. Building B. Wing	03/05/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 26 sampled residents (Resident 73) who received necessary assistive devices to support eating and maintain independence, had a required physician's order for their use.This failure had the potential to affect the resident's safety, dignity, and ability to receive individualized care.Findings:During an observation on 3/2/26 at 12:21 PM in the dining room, Resident 73 was observed sitting in a wheelchair being assisted by staff with lunch. Resident 73 was observed with a plate guard (a curved, plastic, or metal barrier that clips onto the edge of a standard plate used to assist residents while eating) and adaptive utensils (specially designed eating tools used to help individuals who have difficulty feeding themselves due to physical, cognitive, or neuromuscular limitations).A review of Resident 73's admission Record (a document showing a summary of the resident's information), dated 3/4/26, indicated Resident 73 was initially admitted to the facility on [DATE], with diagnoses including displaced fracture of sixth cervical vertebra (one of the seven bones in the neck), muscle wasting and atrophy (weakening, shrinking, and loss of muscle), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).A review of Resident 73's Order Summary Report, dated as of 3/4/26, failed to show a physician's order for the use of the plate guard and adaptive eating utensils.During a concurrent interview and record review on 3/5/26 at 4:05 PM with the Director of Nursing (DON), Resident 73's medical record was reviewed. The DON verified the resident did not have a physician's order for the use of the plate guard and adaptive eating utensils. The DON stated the hospice will usually communicate with the facility's staff regarding any new and current orders, and then the staff will update the residents' orders in the system. The DON stated that obtaining a physician's order was important to ensure the residents receive the appropriate services and to allow staff to reassess the need for adaptive equipment in the future.

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	555747	A. Building B. Wing	03/05/2026

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure IV (Intravenous- fluids given directly into the blood stream) therapy was provided consistently in accordance with the professional standards of practice, physician orders, and comprehensive person-centered care plans for two of four sampled residents (Residents 2 and 59) when:-There was no documented evidence indicating that Resident 2's IV antibiotic was administered on 2/4/26 and 2/5/26 as ordered.-There was no documented evidence that Resident 2's PICC line (Peripherally Inserted Central Catheter - a thin flexible tube inserted to a large vein in the upper arm used to deliver medications for long term treatments) was flushed with normal saline on 2/4/26 and 2/5/26 as ordered. -Resident 2's PICC line dressing had no label.-Resident 59's PICC line dressing was not changed as ordered. Cross reference to F842, Example#1.These failures had the potential to put Residents 2 and 59 at risk for infections and complications that may negatively affect their overall health and well-being.Findings:1a. During an initial tour observation on 3/2/26 at 10:16 AM, inside the resident's room, Resident 2 was awake, alert, and lying on his bed while watching TV. Resident 2's IV antibiotic was infusing via the PICC line on his right upper arm.A review of Resident 2's admission Record, (a document showing a summary of the resident's information) dated 3/3/26, indicated the resident was admitted to the facility on [DATE], with diagnoses that included streptococcal sepsis (a life-threatening bacterial blood infection) and abscess of liver (pus in the liver).A review of Resident 2's physician order, dated 2/2/26 at 09:18 AM, indicated an order to discontinue the following order:-Piperacillin-Tazobactam-NaCl [a type of antibiotic] Intravenous Solution Reconstituted 4-0.5GM/100ML [gram (a metric unit of measurement for mass/weight)/milliliter (a unit of measurement)] (Piperacillin Sodium-Tazobactam Sodium-Sodium Chloride) Use 4.5 gram intravenously every 12 hours for strep septicemia/abscess (a serious bloodstream infection caused by streptococcus bacteria) until 2/5/26 23:59. The order indicated the reason for discontinuation was to change the dose to 3.375 grams IV every 12 hours until 2/5/26 and to infuse the medication over four hours.A review of Resident 2's IV Administration Record, (legal document used to track intravenous medications) dated 2/1/2026 to 2/28/2026, indicated to administer the updated order for Piperacillin-Tazobactam-NaCl 3.375 grams IV every 12 hours starting on 2/2/26 at 9:00 PM. However, there was no documented evidence indicating the medication was administered on 2/4/25 and 2/5/26 at 9:00 PM, as the boxes in the IV Administration Record were left blank.A review of the facility's policy & procedure (P&P) titled GENERAL POLICIES FOR IV THERAPY, dated March 2014, indicated .M. Documentation of IV therapy should include but is not limited to:.IV medication administration.b. A review of Resident 2's Order Summary Report dated as of 3/3/26, indicated orders to Flush PICC line (specify) lumen with 10 ml of normal saline [a salt water solution] every 12 hours for maintenance and Flush PICC line (specify) lumen with 10 ml saline before and after IV medications every 12 hours.A review of Resident 2's IV Administration Record, dated 2/1/2026 to 2/28/2026, indicated to Flush PICC line (specify) lumen with 10 ml of normal saline every 12 hours for maintenance and to Flush PICC line (specify) lumen with 10 ml saline before and after IV medications every 12 hours starting on 1/29/26 at 9:00 PM. However, there was no documented evidence indicating the medications were administered on 2/4/25 and 2/5/26 at 9:00 PM, as the boxes in the IV Administration Record were left blank.During an interview on 3/5/26 at 9:10 AM with Registered Nurse (RN) 2, RN 2 stated that staff were expected to flush the PICC line with normal saline first, administer the antibiotic, and then flush the line again with normal saline. RN 2 also stated staff were expected to document after medication administration to indicate that the task was done.During a concurrent interview and record review on 3/5/26 at 9:34 AM with RN 2, RN 2 reviewed Resident 2's medical record via PCC (PointClickCare- cloud-based electronic health record) and confirmed there was no documented evidence that the staff flushed Resident 2's PICC line and administered the (continued on next page)

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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic on 2/4/26 and 2/5/26 at 9PM.During a concurrent interview and record review on 3/5/26 at 9:46 AM, with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 2's medical record via PCC and stated that she did not see any documentation indicating that the staff flushed Resident 2's PICC line and administered the antibiotic on 2/4/26 and 2/5/26 at 9PM.During a concurrent interview and record review on 3/5/26 at 11:48 AM with the Director of Nursing (DON), the DON reviewed Resident 2's medical record via PCC. The DON verified Resident 2's PICC line flush was missed and there was no documented evidence that Resident 2's antibiotic was administered on 2/4/26 and 2/5/26 at 9 PM.A review of Resident 2's Care Plan Report, indicated the following care plan problems:- Resident requires Enhanced Barrier Precautions ([EBP] - an infection control prevention designed to reduce the transmission of multi-drug-resistant organisms [MDROs] in healthcare settings, particularly nursing homes) related to PICC Line right upper arm on IV Antibiotic therapy for abdominal abscess, Septicemia.Interventions: IV ABX (antibiotic) AS ORDERED .- Altered hepatic function r/t (related to) Liver Abscess [pus in the liver], Liver Cirrhosis [liver disease] with Ascites [buildup of fluids in the abdomen].Interventions .Administer medications as ordered.c. During an initial tour observation on 3/2/26 at 10:16 AM, inside the resident's room, Resident 2 was awake, alert, and lying on his bed while watching TV. Resident 2's IV antibiotic was infusing via PICC line on his right upper arm. The PICC line dressing had no label.During a concurrent observation and interview on 3/2/26 at 11:59 AM with RN 2, RN 2 confirmed that Resident 2's PICC line dressing had no label. RN 2 stated that staff were expected to label the dressing with the date, time, and staff initials. RN 2 added that this was important, so staff knew when to change the dressing and for infection control purposes.A review of Resident 2's Order Summary Report, dated as of 3/3/26, indicated Resident 2 had the following orders: Antimicrobial disc [small, absorbent pad that inhibit bacterial growth] will be utilized for all central/midline sites and changed every 7 days with dressing change. One time a day every Sun. with a start date of 2/1/26 and Change PICC line dressing, Stat-lock [adhesive-based medical device designed to securely hold PICC line in place] every day shift every Sun [Sunday] if gauze dressing is used change every 48 hours. with a start date of 2/1/26. 2. During a concurrent observation and interview on 3/2/26 at 11:28 AM with RN 2, RN 2 read the label of Resident 59's PICC line dressing and confirmed the date written was 2/16/26. RN 2 added that the dressing was normally changed every seven days. Resident 59's dressing change was seven days overdue.A review of Resident 59's admission Record, dated 3/3/26, indicated the resident was readmitted to the facility on [DATE], with diagnoses that included cutaneous abscess of abdominal wall (localized collection of pus caused by bacterial infections, surgical complications, or trauma), malignant neoplasm of the prostate (prostate cancer), and acute osteomyelitis (a serious bone infection causing severe pain, inflammation, fever, and potential bone death).A review of Resident 59's Order Summary Report, dated as of 3/3/26, indicated Resident 59 had the following orders: Antimicrobial disc will be utilized for all central/midline sites and changed every 7 days with dressing change. one time a day every 7 day(s) . with a start date of 2/18/26 and .Change PICC line dressing, Stat-lock every day shift every 7 day(s) if gauze dressing is used change every 48 hours. with a start date of 2/18/26.A review of Resident 59's Progress Notes, dated 2/18/2026, indicated .dressing dated 2/16/26 due on 2/23/26. and Antimicrobial disc will be utilized for all central/midline sites and changed every 7 days with dressing change. One time a day every 7 day(s) .During an interview on 3/5/26 at 10:00 AM with the ADON, the ADON stated that staff were expected to change PICC line dressings every week, on Sundays. The ADON also stated that staff should label the dressing with date and initials every dressing change. The ADON added that this was important for IV site monitoring and infection prevention.During a concurrent interview and record review on 3/5/26 at 11:58 AM with the DON, the DON reviewed Resident 59's medical record via PCC. The DON stated Resident 59's PICC line dressing dated 2/16/26 was from the hospital, and there was no documented evidence that it was changed on 2/23/26. The DON stated Resident 59's PICC line dressing had not been changed since admission.During a follow-up interview on 3/5/26 at 12:10 PM with the DON, the DON stated that (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were expected to follow the facility's P&P for PICC line dressing change.A review of Resident 59's Care Plan Report, indicated .The resident has infection of the Osteomyelitis [inflammation of the bone or bone marrow, usually due to infection] of Pubic Symphysis [the location where the two halves of the pelvic bones meet in front of the body].Anterior abdominal wall abscess.Interventions . Administer IV antibiotic medication as ordered .Change IV dressing per order.A review of the facility's Registered Nurse Supervisor's Job Description, indicated POSITION SUMMARY: The purpose of your job description is to supervise the day-to-day activities of the facility during your shift in accordance with current federal, state, and local standards that govern the facility, and as directed by your management. The Registered Nurse Supervisor.will be committed to always doing the right thing. ESSENTIAL DUTIES AND RESPONSIBILITIES.Monitoring nursing staff to ensure they are complying with resident's care plan.Passing out medications when needed.Abiding with all facility policies and procedures.Following Infection and Control policies.A review of the facility's P&P titled Central Venous Catheter and Dressing Changes, revised March 2022, indicated .The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. General Guidelines: 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised.3. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every 7 days for TSM (Transparent Semi-permeable membrane), b. at least every 2 days for sterile gauze dressing.c. immediately if the dressing or site appear compromised.Procedure to apply sterile dressing:.7. Apply sterile dressing.e. Label with initials, date and time. Documentation: 1. The following information should be recorded in the resident's medical record: a. Date and time dressing was changed.f. signature and title of the person recording the data.

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	555747	A. Building B. Wing	03/05/2026

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Murrieta Health and Rehabilitation Center	24100 Monroe Avenue Murrieta, CA 92562

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an oxygen administration order was obtained for one of five sampled residents investigated for oxygen treatment (Resident 166).This failure could result in Resident 166 experiencing oxygen toxicity (lung damage caused by breathing excessive oxygen at high pressure) due to the administration of excessive or inappropriate supplemental oxygen, potentially leading to respiratory failure (when lungs cannot properly transfer oxygen into blood causing severe breathing difficulty).Findings:During a concurrent observation and interview on 3/2/26 at 10:37 AM with Resident 166, Resident 166 was in bed, alert, and verbally responsive. Resident 166 was receiving oxygen at a rate of four liters per minute through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 166 stated that the previous oxygen administration rate was only two liters per minute, but it was likely that the facility staff received an order to increase the rate.During a concurrent interview and record review on 3/2/26 at 1:40 PM with Licensed Vocational Nurse (LVN) 3, Resident 166's active orders were reviewed. LVN 3 verified that Resident 166's order for oxygen administration was at two liters per minute at bedtime, and Resident 166 had no orders for oxygen administration during daytime and/or as needed. LVN 3 stated that the attending physician should be notified to obtain an oxygen administration order during daytime and/or as needed and adjust the parameters accordingly.During an interview on 3/4/26 at 3:47 PM with Registered Nurse (RN) 1, RN 1 emphasized the importance of obtaining a physician's order for oxygen administration, noting that excessive administration of oxygen could potentially result in hyperventilation (rapid or deep breathing) for the resident.During an interview on 3/4/26 at 4:06 PM with the Director of Nursing (DON), the DON stated that oxygen administration required a physician's order and should be followed within the scope of practice.A review of Resident 166's admission Record (a document showing a summary of the resident's information), dated 3/2/26, indicated Resident 166 was readmitted to the facility on [DATE], with diagnoses which included asthma (a long term chronic condition that makes it difficult to breathe because the lungs airways become swollen and narrowed) and obstructive sleep apnea (a serious disorder where breathing repeatedly stops and starts during sleep because throat muscles relax and causing the airway to collapse).A review of the facility's policy and procedure titled Oxygen Administration, revised October 2010, indicated .The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation.1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure accurate accountability of controlled substances (controlled substance [CS] - medications with high potential for abuse and addiction) when:The Controlled Drug Records ([CDR] - a medication count sheet, an inventory record used to document the receipt, use, and count of controlled substances) for one out of nine randomly selected residents (Resident 56) did not reconcile with the Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident).These failures resulted in inaccurate accountability of controlled substances, which had the potential for diversion (medication taken by someone other than for whom it is prescribed) or misuse of controlled substances and had the potential to compromise the residents' medication therapy and safety.Findings:During an inspection of Medication Cart 2A at Nursing Station 200 on 3/3/26 at 11:43 AM, a blister card for oxycodone-acetaminophen (generic for Percocet, a controlled narcotic mediation for pain) 5-325 mg (milligram - a unit of measurement) labeled for Resident 56 was concurrently reviewed with Licensed Vocational Nurse (LVN) 6.A review of Resident 56's physician order, dated 12/11/25, indicated an order for oxycodone-acetaminophen 5-325 mg, give 1 tablet by mouth every 4 hours as needed for severe pain 7-10 (pain scale).A review of Resident 56's CDR and January 2026 MAR indicated the nursing staff removed and signed out one tablet of oxycodone-acetaminophen 5-325 mg on 1/14/26 at 6:40 AM and 1/24/26 at 7:10 AM, but there was no corresponding documentation of administrations and pain assessments on the MAR.During a concurrent interview and record review on 3/3/26 at 11:43 AM with LVN 6, LVN 6 confirmed the discrepancy and stated the CS administration was required to be documented on both the CDR and the MAR.During a concurrent interview and record review on 3/3/26 at 4:16 PM with the Director of Nursing (DON) in the DON's office, the DON confirmed discrepancies between the CDR and the MAR for Resident 56, including documented CS removals without corresponding MAR documentation of administration. The DON stated her expectation for the nursing staff was to document the CS removal on the CDR and medication administration on the MAR.A review of the facility's policy and procedures titled, Administering Medications, dated April 2019, indicated .As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.e. any complaints or symptoms for which the drug was administered .f. any results achieved and when those results were observed; and g. the signature and the title of the person administering the drug.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and facility record review, the facility failed to ensure the kitchen staff had the appropriate skill set to safely perform the daily operations of the Food and Nutrition Services Department.Dietary Aide (DA) 2 was unable to correctly explain the procedures to test the chemical concentration measured in parts per million (ppm - a unit of measurement) of the quaternary sanitizing solution (a chemical solution used to kill germs on surfaces) to sanitize food contact surfaces.This failure had the potential to expose 131 of 132 highly susceptible residents who received food from the kitchen to foodborne illnesses (any illness resulting from eating contaminated/spoiled foods) due to cross- contamination (the transfer of harmful substances or disease- causing microorganisms to food). During an observation and interview on 3/2/26 at 3:30 PM with DA 2, DA 2 was asked to demonstrate how to check the sanitizing solution. DA 2 stated she was not sure.A review of DA 2's personnel files indicated DA 2's date of hire was 3/18/25. During a concurrent interview and record review on 3/2/26 at 3:50 PM with the Director of Dietary Services (DDS), the DDS stated staff were supposed to dip the test strip into the sanitizing solution for ten seconds, then match the color to the chart. The DDS added that the solution should be between 200-400 ppm. When asked to review the competency skills for DA 2, the DDS stated he was unable to locate DA 2's competency skills check. The DDS stated the competency skills check should have been completed within three months after hire. The DDS stated it was important to check that the quaternary sanitizer was within range to effectively sanitize and prevent foodborne illnesses.A review of the facility' s policy and procedures titled Sanitization, dated November 2022, indicated the service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure complete, accurate, and consistent documentation for two of 26 sampled residents' (Residents 59 and 60) medical records when:Resident 59's medical record did not accurately reflect the resident's PICC line (Peripherally Inserted Central Catheter - a thin flexible tube inserted to a large vein in the upper arm used to deliver medications for long term treatments) dressing change. 2. Resident 60's activity records were not accurately and consistently completed. These failures had the potential for these two residents to receive inconsistent care coordination and unmet care needs. Findings:1. During an initial tour observation on 3/2/26 at 9:38 AM, in the resident's room, Resident 59 was awake, verbally responsive, and comfortably lying on his bed. Resident 59 had a PICC line dressing on his right upper arm dated 2/16/26. During a concurrent observation and interview on 3/2/26 at 11:28 AM with Registered Nurse (RN) 2, RN 2 read the label of Resident 59's PICC line dressing and confirmed the date written was 2/16/26. RN 2 added that the dressing was normally changed every seven days. Resident 59's dressing change was seven days overdue. A review of Resident 59's admission Record, (a document showing a summary of the resident's information) dated 3/3/26, indicated the resident was readmitted to the facility on [DATE], with diagnoses that included cutaneous abscess of abdominal wall (localized collection of pus caused by bacterial infections, surgical complications, or trauma), malignant neoplasm of the prostate (prostate cancer), and acute osteomyelitis (a serious bone infection causing severe pain, inflammation, fever, and potential bone death). A review of Resident 59's Order Summary Report, dated as of 3/3/26, indicated Resident 59 had the following orders: Antimicrobial disc [small, absorbent pad that inhibit bacterial growth] will be utilized for all central/midline sites and changed every 7 days with dressing change. one time a day every 7 day(s) . with a start date of 2/18/26 and .Change PICC line dressing, Stat-lock [adhesive-based medical device designed to securely hold PICC line in place] every day shift every 7 day(s) if gauze dressing is used change every 48 hours. with a start date of 2/18/26. A review of Resident 59's IV Administration Record, (a legal document used to track intravenous medications) dated 2/1/2026 to 2/28/2026, indicated the following items were completed and signed off by staff on 2/18/26 and 2/25/26: -Antimicrobial disc will be utilized for all central/midline sites and changed every 7 days with dressing change. one time a day every 7 day(s) which started on 2/18/26 at 9:00 AM.-Change PICC line dressing, Stat-lock every day shift every 7 day(s) if gauze dressing is used change every 48 hours which started on 02/18/2026 at 7:00 AM. A review of Resident 59's Progress Notes, dated 2/18/2026, indicated .dressing dated 2/16/26 due on 2/23/26. and Antimicrobial disc will be utilized for all central/midline sites and changed every 7 days with dressing change. One time a day every 7 day(s) . During a concurrent interview and record review on 3/5/26 at 11:58 AM, with the Director of Nursing (DON), the DON reviewed Resident 59's medical record via PCC (PointClickCare - a cloud-based (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic health record). The DON stated Resident 59's PICC line dressing dated 2/16/26 was from the hospital, and there was no documented evidence that it was changed on 2/23/26. The DON also stated that the IV Administration Record that indicated the dressing was changed on 2/25/26 was inaccurate and Resident 59's PICC line dressing had not been changed since admission. The DON reviewed the facility's policy and procedure (P&P) titled Charting and Documentation, revised July 2017, and stated the policy was not followed. A review of the facility's P&P titled, Charting and Documentation revised July 2017, indicated . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record shall facilitate communication between interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation:.2. The following information is to be documented in the resident medical record:.c. Treatments or services performed; 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time, the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care;.e. whether the resident refused the procedure/treatment;.g. the signature and title of the individual documenting. 2. During an observation on 3/3/26 at 10:41 AM, in the resident's room, Resident 60 was resting in bed with her eyes closed while the television was on in English. A review of Resident 60's admission Record, dated 3/4/26, indicated the resident was initially admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized anxiety disorder. A review of Resident 60's Care Plan Report indicated a care plan problem including The resident has daily preferences and/or activity preferences. Resident is visited daily and is on a one-to-one room visit with sensory motor stimuli to touch and small conversation. Interventions included that the resident prefers to choose their own bedtime. During a concurrent interview and record review on 3/3/26 at 4:09 PM with the Activities Director (AD), Resident 60's Event Calendar Report for February 2026 was reviewed. Resident 60's Event Calendar Report for February 2026 indicated on 2/18, 2/24 and 2/25/26, no activities were documented. The AD stated Resident 60 was visited daily. The AD verified the dates did not contain entries to show activities were provided to Resident 60. The AD stated it was important to log the activities provided to ensure all residents were receiving activities that were not only important for their cognition, but also for their psychosocial well-being. Additionally, the AD stated it helped to keep track of activities the residents liked and preferred. A review of the facility's P&P titled Room Visit Program Independent Activities, (undated), indicated .Room visit program and independent activities are recorded on the Activity Attendance Record form.Room visit records are kept in the activity office as part of the attendance record keeping system. This includes the date of the visit, the activity provided and the resident's response .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to keep the resident call light system (a device that residents can press to ask staff for help) in good working order for two of 26 sampled residents (Residents 13 and 171). This failure had the potential to delay staff response to resident needs and compromise resident safety.Findings:During a concurrent observation and interview on 3/2/26 at 8:59 AM with Certified Nursing Assistant (CNA) 1, CNA 1 tested the call light system in Resident 13 and Resident 171's rooms. Both call light systems did not show a light or were audible at the nursing station. CNA 1 verified that the call light system for both residents was not working.During a concurrent follow-up observation and interview on 3/2/26 at 11:59 AM with CNA 1, CNA 1 tested the call light system in Resident 13 and Resident 171's rooms again. Both call light systems still did not show a light or were audible at the nursing station. CNA 1 verified that the call light system for both residents were still not working.During an interview on 3/2/26 at 12:12 PM with CNA 1, CNA 1 was asked about the facility's process when the call light system malfunctioned. CNA 1 stated the facility placed a call bell at the bedside table, so the residents can alert the staff if needed. CNA 1 stated she already placed a request to notify maintenance of the issue.During an interview on 3/4/26 at 10:54 AM with the Maintenance Assistant (MA), the MA confirmed he was aware of Resident 13 and 171's nonfunctioning call lights and stated that he had already fixed the issue. The MA stated he replaced the call light system on the wall and tested them to ensure they were functioning properly.A review of the facility's policy and procedure titled Call System, Residents, dated 9/2022, indicated .Residents are provided with a mean to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. 2. Call system communication may be audible or visual. The system may be wired or wireless.3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional.