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	08/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47832 Based on interview and record review, the facility failed to ensure a thorough assessment of the wounds and notification to the physician after a change of condition was identified for one of three sampled residents (Resident 1). This failure has the potential to result in worsening of the pressure injuries (skin or soft tissue injuries that form due to prolonged pressure exerted over specific areas of the body), acquired by Resident 1, resulting in infection and a decline in health. Findings: On July 23, 2024, at 9:34 a.m., an unannounced visit was conducted at the facility to investigate a quality-of-care issue. A review of Resident 1's medical record indicated initial admission was on July 2, 2023, with diagnosis which included fracture of right femur (thigh bone), glaucoma (eye condition that can cause blindness), hypertension (force of the blood against the artery walls is too high), heart failure (heart does not pump blood well), Covid 19 (caused by a virus which can be contagious and spread quickly), dementia (impairs memory loss and judgement), urinary tract infection (infection of organs that makes urine), difficulty walking, need for assistance with personal care, long term use of anticoagulants (blood thinner). A review of Resident 1's Braden Scale for Predicting Pressure Score Risk assessment dated [DATE], indicated a Braden Score (consists of six subscales and the total scores range from 6-23. A lower Braden scores indicates higher level of risk for pressure ulcer development) of 13, indicating resident was at moderate risk for developing pressure injury. A review of Resident 1's Progress Notes dated August 7, 2023, by Licensed Vocational Nurse (LVN 1) indicated, .res (resident) had blood blister that opened on the left buttock . A review of Resident 1's Progress Notes dated August 8, 2023, by the Treatment Nurse (TN) indicated, .new skin breakdown/discoloration noted to right heel, started on 08/08/2023 in the morning . A review of the document titled Skin Assessment did not indicate a complete assessment was completed per facility policy after wounds on the left buttock and right heel were identified. On July 23, 2024, at 12:50 p.m., during an interview Certified Nursing Assistant stated any change in skin condition of a resident was reported right away to the wound nurse. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 23, 2024, at 1:12 p.m., during an interview Licensed Vocational Nurse (LVN 2) stated any change in skin condition was notified to the treatment nurse who documented the change of condition. LVN 2 stated if a resident had a change of condition related to skin, the treatment nurse completed a full assessment. On July 23, 2024, at 1:38 p.m., during a concurrent interview and record review TN stated if a resident had a change in condition related to skin, a skin assessment was completed right away. TN stated when Resident 1 came into the facility, had no pressure injuries on admission. TN confirmed Resident 1 had a change of condition with a blood blister on the buttock on August 7, 2024, and discoloration to the right heel on August 8, 2024. TN also stated a photo and assessment of the blood blister on the buttock and discoloration to the right heel was not completed after a change of condition was noted. On July 23, 2024, at 2:26 p.m., during a concurrent interview and record review with the Director of Nursing (DON) stated per policy after TN identified the wounds on August 7th and 8th 2024, should have documented the wound description, location, if pressure injury or non-pressure injury, length, width, depth, presence of exudate (fluid that leaked out of blood vessels) or necrotic tissue (death of body tissue). DON confirmed there was no assessment completed by the TN after a change of condition was identified for the blood blister on the buttock and discoloration to the right heel. A review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol revised April 2018, indicted, .the nurse shall describe and document/report .full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue, pain assessment, resident's mobility status, current treatments .current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions .