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	08/07/2024

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 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** 47832 Based on interview and record review, the facility failed to accurately document in the Electronic Medication Administration Record (EMAR) scheduled time of medication administration, for one of three residents (Resident 1). This deficient practice can have the potential for inappropriate communication between the staff and an inaccurate picture of resident's care. Findings: On August 7, 2024, at 8:55 a.m., an unannounced visit was conducted at the facility to investigate a complaint for quality of care, accidents, physical environment, and a nursing services issue. On August 7, 2024, Resident 1's facility medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with a diagnosis which included rhabdomyolysis (breakdown of muscle tissue that releases damaging protein into the blood), heart failure (heart does not pump blood well), hypertension ((force of blood against the artery wall is too high) and dementia (group of conditions which impairs memory loss and judgement). A review of Resident 1's physician orders indicated the following: - Clopidogrel bisulfate (blood thinner) 75 milligrams (mg-unit of measurement), give one tablet by mouth one time a day; order dated July 14, 2024. - Colace (stool softener) 100 mg give one tablet by mouth one time a day; order dated July 14, 2024, - Famotidine (medication to treat heartburn) 20 mg give one tablet one time a day; order dated July 15, 2024; and - Losartan Potassium (medication to treat high blood pressure) 50 mg give one tablet by mouth one time a day; order dated July 19, 2024. A review of the facility document titled Medication Admin (administration) Audit Report, a report indicating the medication's scheduled date and time for administration (giving the medication to the resident) and the documented time stamp of when the medication was actually given, indicated the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Clopidogrel 75 mg, scheduled time 9 a.m., administered time 3:55 p.m. - Colace 100 mg, scheduled time 9 a.m., administered time 3: 56 p.m. - Famotidine 20 mg, scheduled time 9 a.m., administered time 3:56 p.m.; and - Losartan 50 mg, scheduled time 9 a.m., administered time 3:56 p.m. On August 9, 2024, at 2: 42 p.m., during an interview with Licensed Vocational Nurse (LVN 2) who stated, was a new nurse, administered the medications at the scheduled time but did not document as administered right away. LVN 2 stated later went back to the EMAR and documented as administered. LVN 2 also stated medications should not be administered late. On August 12, 2024, at 10:03 a.m., during an interview with the Director of Nursing (DON), the DON stated Resident 1's medication scheduled to be administered at 9 a.m., was documented as administered at 3: 55 p. m. The DON stated the medications administered should be documented timely for resident safety. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, . Medications are administered in accordance with prescriber orders, including any required time frame .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .