

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Meadowbrook Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 461 E. Johnston Avenue Hemet, CA 92543	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe storage practice was followed in accordance with the professional standards of practice when a gallon of chocolate syrup with an open date of October 19, 2023, was found on top of the kitchen overhead counter, readily available for use.</p> <p>This failure had the potential to cause food-borne illnesses in a medically vulnerable population who consumed food in the facility.</p> <p>Findings:</p> <p>On May 12, 2025, at 12:12 p.m., during a brief kitchen tour with the Dietary Manager (DM), a gallon of chocolate syrup with an open date of October 19, 2023, was found on top of the kitchen overhead counter, readily available for use.</p> <p>In a concurrent interview with the DM, he stated the chocolate syrup should have been discarded one year after it was opened on October 19, 2023. He stated the chocolate syrup was only good for one year once opened. The DM stated the chocolate syrup should have been thrown away so the kitchen staff will not use it. He also stated expired food can cause stomach upset or stomach illnesses.</p> <p>On May 12, 2025, at 4:45 p.m., during a telephone interview with the Registered Dietician, she stated the facility should follow the guidelines for storing dry goods with regards to expiration dates and open dates. She stated there should be no expired food or food stored in the kitchen longer than the shelf life, whether it was opened or not.</p> <p>A review of the facility document titled, DRY GOODS STORAGE GUIDELINES, dated 2018, indicated, . FOOD ITEM .Chocolate Syrup .OPENED ON SHELF .6 (six) months .</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when the dumpster was found overflowing with trash. In addition, the lid of the dumpster was not completely closed.</p> <p>This failure had the potential to attract pests.</p> <p>Findings:</p> <p>On May 12, 2025, at 12:33 p.m., during a garbage disposal inspection with the Dietary Manager (DM), a trash dumpster located outside the building by the parking lot area was observed overflowing with trash. In addition, the lid of the dumpster was not completely closed.</p> <p>In a concurrent interview with the DM, he stated the dumpster should not be overflowing with trash. He also stated, the dumpster lid should be completely closed to prevent attracting pests.</p> <p>On May 12, 2025, at 12:25 p,m, during an interview with the facility owner, he stated the dumpster should not be overflowing and the lid should be completely closed.</p> <p>A review of the facility policy and procedure, titled, Food-Related Garbage and Refuse Disposal, revised October 2017, indicated, .Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection control practice was followed for two of three residents reviewed (Residents 1 and 2) when:</p> <ol style="list-style-type: none"> 1. For Resident 1, the oxygen (O2) cannula (a flexible tube with two prongs that fit into the nostrils and delivers supplemental O2) was not dated and an undated nebulizer mask (a medical device that fits over the nose and mouth and allows an individual to inhale a mist of medication directly into their lungs) was found on top of Resident 1 ' s nightstand. In addition, the undated nebulizer mask was not stored in a plastic bag and was exposed to the environment; and 2. For Resident 2, the nebulizer mask was not changed since admission. <p>These failures had the potential for Residents 1 and 2 to be exposed to bacterial cross contamination and the development of infection.</p> <p>Findings:</p> <p>1. On May 12, 2025, at 11:18 a.m., Resident 1 was observed sitting in bed, awake and alert. Resident 1 was receiving O2 at 2 (two) LPM (Liters Per Minute &ndash; a unit of measurement). The O2 tubing was not dated. In addition, a nebulizer mask was found on top of the nightstand, not stored in a plastic bag and was exposed to the environment. The nebulizer mask was not dated.</p> <p>Resident 1 ' s record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included pneumonia (lung infection). The physician order dated January 20, 2025, indicated, .Change nasal cannula/mask every night shift every Sun (Sunday) .Change O2 tubing every night shift every Sun .</p> <p>On May 12, 2025, at 11:40 a.m., Licensed Vocational Nurse (LVN) 1 was observed changing O2 plastic bag in resident ' s rooms.</p> <p>In a concurrent interview with LVN 1, he stated the O2 cannula, O2 plastic bag, and the nebulizer mask should be changed once a week. LVN 1 stated the night shift nurses were assigned to change them on Sunday night. He also stated the O2 cannula and the nebulizer mask should be stored in a clear plastic bag, labeled, and dated when not in use. LVN 1 stated the O2 cannula, and the nebulizer mask should not be left exposed for infection control.</p> <p>On May 12, 2025, at 11:48 a.m., the Respiratory Therapist (RT) was interviewed. He stated respiratory equipment such as nasal cannula and nebulizer mask should be changed once a week. He stated the respiratory equipment should be labeled, dated, and stored in a clean plastic bag when not in use for infection control purposes.</p> <p>On May 12, 2025, at 12:43 p.m., the Director of Staff Development (DSD) stated he was the acting Infection Preventionist (IP). He stated the RT would change the respiratory equipment every Monday for those residents assigned to them and the night shift Charge Nurse should change the respiratory equipment on Sunday night. He also stated, the nasal cannula, and the nebulizer mask should be stored in a clear plastic bag for infection control and should be changed once a week.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy and procedure titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated, .Steps in the Procedure .store in a plastic bag with the resident ' s name and the date on it .Change equipment and tubing every seven days, or according to the facility protocol .</p> <p>2. On May 12, 2025, at 11:08 a.m., a resident belongings bag was observed hanging, attached to the drawer knob of Resident 2 ' s nightstand. The belongings bag indicated, .(Name of Resident 2) .Neb (nebulizer) mask .4/9/25 . Resident 2 was not in his room.</p> <p>A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included pneumonia.</p> <p>A review of Resident 2's physician order dated April 9, 2025, indicated, .Change nasal cannula/mask every nigh shift every Sun .Change O2 tubing every night shift every Sun for hygiene .</p> <p>On May 12, 2025, at 11:40 a.m., Licensed Vocational Nurse (LVN) 1 was observed changing O2 plastic bag in resident ' s rooms.</p> <p>In a concurrent interview with LVN 1, he stated the O2 cannula, O2 plastic bag, and the nebulizer mask should be changed once a week. LVN 1 stated the night shift nurses were assigned to change them on Sunday night. He also stated the O2 cannula and the nebulizer mask should be stored in a clear plastic bag, labeled, and dated when not in use. LVN 1 stated the O2 cannula, and the nebulizer mask should not be left exposed for infection control.</p> <p>On May 12, 2025, at 11:48 a.m., the Respiratory Therapist (RT) was interviewed. He stated respiratory equipment such as nasal cannula and nebulizer mask should be changed once a week. He stated the respiratory equipment should be labeled, dated, and stored in a clean plastic bag when not in use for infection control purposes.</p> <p>On May 12, 2025, at 12:43 p.m., the Director of Staff Development (DSD) stated he was the acting Infection Preventionist (IP). He stated the RT would change the respiratory equipment every Monday for those residents assigned to them and the night shift Charge Nurse should change the respiratory equipment on Sunday night. He also stated, the nasal cannula, and the nebulizer mask should be stored in a clear plastic bag for infection control and should be changed once a week.</p> <p>On May 12, 2025, at 2:18 p.m., Resident 2 was observed in the Activities Room, sitting in the wheelchair. He stated his nebulizer mask had not been changed since he was admitted in the facility.</p> <p>On May 12, 2025, at 2:40 p.m., LVN 2 was interviewed. LVN 2 stated she gave Resident 2 ' s breathing treatment in the morning and did not change the nebulizer mask. LVN 2 stated the respiratory equipment should have been changed Sunday, by the night shift. She also stated respiratory equipment should be stored in a plastic bag when not in use.</p> <p>A review of the facility policy and procedure titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated, .Steps in the Procedure .store in a plastic bag with the resident ' s name and the date on it .Change equipment and tubing every seven days, or according to the facility protocol .</p>		