STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055401	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Post Acute	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes) when one of three sampled residents (Resident 1) was transferred to a general acute care hospital. This failure has the potential for the Ombudsman not be able to advocate for the residents in protecting their rights from inappropriate transfer and discharge. Findings: A review of Resident 1 ' s admission record indicated resident was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar), hypertension (high blood pressure), osteomyelitis right foot (bone infection), and chronic kidney disease (gradual loss of kidney functions). Further review of the record indicated the resident was transferred to an acute care hospital on June 10, 2025. A review of Resident 1 ' s Progress Note date June 10, 2025, at 1:45 p.m., indicated .received new orders . Resident sent out to[name of hospital] .gangrene right foot .physician made aware .resident family made aware . A review of Resident 1 ' s SBAR (Situation, Background, Assessment, and Recommendation) dated June 10, 2025, indicated .resident returned from medical appointment .received new orders to transfer resident to Inland Valley Hospital .gangrene right foot . On June 25, 2505, at 1:41 p.m., an interview and concurrent record review was conducted with the Social Worker (SW). The SW stated Resident 1 was transferred to a general acute care hospital on June 10, 2025, for gangrene of the right foot. The SW verified there was no documented evidence the ombudsman was notified of Resident 1's transfer to the hospital. The SW further stated the ombudsman should be notified of transfers and she should have followed up on the transfer to assure the ombudsmen was notified. (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 25, 2505, at 1:46 p.m., an interview and concurrent record review was conducted with the Director of Nursing (DON) and the Administrator. The DON stated the facility process is for nursing to fax the ombudsman when a resident is being transferred or discharged and the SW is to follow up on all transfer and discharge for notification of the ombudsman. The DON stated the ombudsman should have been notified. The Administrator verified there was no documented evidence the ombudsman was notified of Resident 1 transfer June 10, 2025. The Administrator stated the facility should have notified the ombudsman of Resident 1 transfer. A review of the facility policy and procedure titled Transfer or Discharge, Facility-Initiated, dated October 2022, indicated .Notice of Transfer or Discharge .when residents are sent emergently to an acute care setting .the notice is given as soon as it is practicable but before the transfer or discharge .Notice of Transfer is provided to the resident .resident representative .as soon as practicable before the transfer .(LTC) ombudsman when practicable .monthly list of residents .includes all notice content requirements .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure wound care treatments were provided to meet the needs of residents when four sampled residents ' (Residents 1, 2, 3, and 4) were not provided wound care treatment in accordance with the physician ' s orders. This failure had the potential for Resident 1, Resident 2, Resident 3, and Resident 4 ' s wounds to worsen and could lead to serious complications. Findings: On June 25, 2025, at 9:37 a.m., Resident 1 ' s admission record indicated resident was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar), hypertension (high blood pressure), osteomyelitis right foot (bone infection), and chronic kidney disease (gradual loss of kidney functions). A review of Resident 1 ' s Order Summary Report from April 1, 2025, to June 25, 2025, indicated the following: a. Clean right foot stump wound with Normal Saline and pat dry apply betadine and cover with kerlix and secure with tape. Change as needed if becomes soiled. One time a day for wound care until 05/16/2025. Start date: 05/09/2025. b. Cleanse right foot stump wound with Normal Saline and pat dry apply betadine and cover with kerlix and secure with tape. Change as needed if becomes soiled. One time a day for wound care until 05/23/2025. c. Cleanse right foot stump wound with normal saline and pat dry apply betadine and cover with kerlix and secure with tape. Change as needed if becomes soiled. One time a day for wound care until 05/30/2025. d. Cleanse right foot stump wound with normal saline and pat dry apply betadine and cover with kerlix and secure with tape. Change as needed if becomes soiled. One time a day every other day for wound care for 14 days. Start date 05/31/2025 End date 06/14/2025. A review of Resident 1 ' s Treatment Administration Record (TAR) for the month of May 2025, indicated treatment for the right foot stump was not signed as provided on May 14, 16, and 17, 2025, at 9 a.m. On June 25, 2025, at 10:58 a.m., Resident 2 ' s admission record indicated resident was admitted to the facility on [DATE], with diagnoses which included low back pain, congestive heart failure (heart can ' t pump blood well enough leading to fluid (congestion) build up in body), and hypertension (high blood pressure). A review of Resident 2 ' s TAR for the month of May 2025 indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Cleanse left heel wound with normal saline apply Betadine and leave area open to air. One time a day for wound management until 05/09/2025, Start date:05/03/2025. The TAR has no documentation indicating treatment for the left heel was provided on May 4,2025. b. Cleanse left heel wound with normal saline apply Betadine and leave area open to air. One time a day for wound management until 05/23/2025, Start Date: 05/16/2025. The TAR has no documentation indicating treatment was provided for the left heel on May 17, 2025. c. Cleanse left heel blister with normal saline and pat dry and apply betadine and leave open to air. One time a day for a wound care to left heel blister until June 6, 2025. The TAR has no documentation indicating treatment was provided to the left heel blister on May 31, 2025. On June 25, 2025, at 11:38 a.m., Resident 3 ' s admission record indicated resident was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar), chronic obstructive pulmonary disease (lung disease that makes it hard to breath), and dysphagia (difficulty swallowing). A review of Resident 3 ' s TAR for the month of May 2025 indicated the following: a. Cleanse left great toe with normal saline and pat dry and apply triple Antibiotic and leave open to air. One time a day for treatment to left great toe for 14 days, Start Date: 05/16/2025. The TAR has no documentation indicating treatment was provided on May 16 and 17, 2025. On June 25, 2025, at 9:37 a.m., Resident 4 ' s admission record indicated resident was admitted to the facility on [DATE], with diagnoses which included subdural hemorrhage (blood collects in brain), gangrene (death of body tissue), palliative care (specialized medical care). A review of Resident 4 ' s TAR for the month of May 2025 indicated the following: a. Left foot 4th gangrene toe. Cleanse with NS wound cleanser, pat dry, then apply betadine. Cover with clean dry dressing daily and prn for dislodgement and soiled dressing. Every 48 hours for wound care to left foot until 05/30/2025, Start date: 05/15/2025. The TAR has no documentation indicating treatment was provided to the left foot 4th great toe on May 17, 2025. On June 25, 2025, at 1:03 p.m., an interview and concurrent record review was conducted with the Treatment Nurse. The Treatment Nurse stated there was no documented evidence that the wound treatment was administered on Resident 1's right foot stump on May 14, 15, nd 17, 2025. The TN verified as well that no treatment was provided for Resident 2's left heel wound on May 4, 17, and 31, 2025. For Resident 3's left great toe, the treatment nurse verified no treatment was documented on May 16 and 17, 2025; and For Resident 4's left foot 4th gangrene toe, no treatment was provided on May 17, 2025. The Treatment Nurse stated that wound treatments should have been administered to Resident 1, Resident 2, Resident 3, and Resident 4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 25, 2025, at 2:04 p.m., an interview and concurrent record review was conducted with the Director of Nursing (DON). The DON verified there was no documented evidence that the wound treatment was administered on Resident 1, Resident 2, Resident 3, and Resident 4. The DON stated the facility process is for nursing to follow all physician orders and document that the order has been performed in the resident ' s chart. The DON stated that wound treatment should have been administered to Resident 1, Resident 2, Resident 3, and Resident 4. A review of the facility policy and procedure titled Charting and Documentation, revised July 2017, indicated . The following information is to be documented in the resident medical record .treatments or services performed . documentation of procedures and treatments will include care-specific details .date .time . procedure/treatment . assessment .unusual findings .resident tolerance of the treatment .refusal . signature . title of individual documenting .