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	12/30/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment and ensure adequate supervision was provided to prevent accidents for one of three residents reviewed (Resident 1), who was at risk for falls, self harm, and exhibited impulsive behavior, as indicated in the plan of care and facility policy.These failures resulted in Resident 1 having eight unwitnessed falls between July 2024 and December 2025. On May 13, 2025, Resident 1 sustained a hematoma (severe bruising with swelling) and a skin tear to her forehead. On December 21, 2025, Resident 1 was found on the floor under her roommate's bed, with two red, swollen eyes, which required Resident 1's transfer to the General Acute Care Hospital (GACH) for evaluation and treatment.Findings:On December 24, 2025, at 9:49 a.m., Resident 1 was observed at the GACH, alert and in bed with noticeable injuries to both eyes and hands. The resident's right eye was swollen with a reddish-black color, and the left eye was swollen with a bluish-black color. Additionally, there was purple discoloration on the outer side (lateral side) of her right hand and purple discoloration on her left hand between the index and middle fingers.The GACH emergency department (ED) note dated December 22, 2025, was reviewed and indicated, .female presents to ED for fall.patient currently at (name of skilled nursing facility).staff reported found patient on the floor yesterday around noon. unwitnessed fall.stated patient could not sit still for x-ray.and sent to ED.bilateral (both) black eyes.CT Brain (Computed Tomography-medical device used to scan the brain).no acute intracranial hemorrhage (bleeding inside the skull).admitted to tele unit (special-unit for remote vital sign monitoring) for observation.The left-hand x-ray report dated December 23, 2025, was reviewed and indicated .no radiograph evidence of acute process (fracture).On December 24, 2025, at 10:37 a.m., during a concurrent interview and review of the GACH ED notes with the GACH medical doctor (MD), the MD stated Resident 1 has dementia and requires a sitter (a trained caregiver providing one-on-one observation and support to patients at high risk of harm) for direction and staying in bed while at the GACH. The MD stated the family informed him of Resident 1's history of falls at the skilled nursing facility. The MD further stated that without a dedicated sitter Resident 1 was at risk for falling. On December 24 and 26, 2025, unannounced visits were made to the facility.On December 24, 2025, at 12:44 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated on December 21, 2025, she was Resident 1's assigned CNA. CNA 1 stated at 11:30 a.m., she noticed Resident 1 under her roommate's bed, both of her eyes were red and swollen. CNA 1 stated Resident 1 has a history of being found underneath her roommate's bed, which requires two CNAs to return Resident 1 back to her bed. CNA 1 stated Resident 1 also has a history of hitting herself against objects when she is upset. CNA 1 stated she did not report her 11:30 a.m., findings of Resident 1 being found under her roommate's bed with both eyes red and swollen to the LVN (Licensed Vocational Nurse). CNA 1 stated she told CNA 2 (Resident 1's assigned CNA for the evening shift (3-11 pm) to report Resident 1's swollen eyes since it was change of shift. CNA 1 stated she should have reported Resident 1's swollen eyes to the LVN prior to the shift change.During an interview on December 24, 2025, at 12:59 p.m., CNA 2 stated she was Resident 1's assigned CNA during the evening shift (3-11 pm) on December 21, 2025. CNA 2 stated she was informed by CNA 1 of Resident 1's eyes being swollen and purple. CNA 2 stated she informed the LVN. CNA 2 further stated Resident 1 is uncontrollable and the CNAs have reported it to the Assistant DSD (Director of Staff Development) who stated the resident is ok to come out of bed and that she could not be restrained. CNA 2 stated Resident 1 has never been assigned a one-on-one sitter even though the CNAs keep informing the DON (Director of Nursing) and the (DSD) Director of Staff Development that Resident 1 keeps getting hurt and getting out of bed.On December 24, 2024, Resident 1's medical records were reviewed.Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of intellectual functioning), anxiety (excessive worry or fear), and history of falls.The history and physical completed on July 15, 2024, indicated Resident 1 does not have capacity to make decisions.The BIMS (brief interview for mental status) score dated October 20, 2025, indicated .severely impaired.The care plans were reviewed and indicated the following: -November 7, 2024, .resident has an actual unwitnessed fall. intervention.CNA to check and change resident every 2 hours and as needed.There was no documented evidence in Resident 1's medical record of Resident 1 being checked and changed by the CNAs every 2 hours.-March 14, 2025, .expected behavior related to movement to floor mat.history of falls.per daughter patients cultural (sic) is to sit on the floor every day and do activities and task intervention frequent visual