

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  04/07/2026
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to maintain a safe and clean homelike environment, when the bathroom for two residents (Resident 1 and 2) and the bedroom for one resident (Resident 1) was observed with damaged drywall, missing tiles, and areas of walls not painted. This failure resulted in residents not being provided with a homelike environment in the bathroom and bedroom. Findings: On April 7, 2026, an unannounced visit to the facility was conducted to investigate a complaint related to administration/personnel, misappropriation of property, physical environment, quality of care/treatment and rehabilitation services. On April 7, 2026, at 10:20 a.m., an observation was conducted in Resident 1's room and bathroom. A white patch of dry primer was observed on the wall near the foot of Resident 1's bed. The area was not painted like the rest of the paint color in Resident 1's bedroom. The bathroom, shared between residents in room [ROOM NUMBER] and residents in room [ROOM NUMBER], was also observed. The bathroom had peeled paint on top of the sink right above the faucet, damaged drywall and missing paint around the light switch, missing tiles and grout at the shower area and a patch of dry, white primer around the toilet, not painted like the rest of the bathroom. On April 7, 2026, at 10:25 a.m., an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 came into Resident 1's room and confirmed the wall at the foot of Resident 1's bed was not painted. CNA 1 confirmed Resident 1's bathroom had peeled paint on top of the sink, damaged drywall and missing paint around the light switch, missing tiles and grout at the shower area and a patch of dry, and unpainted area on the wall around the toilet. CNA 1 stated the bedroom and the bathroom of Resident 1 were not like a homelike environment. On April 7, 2026, at 10:42 a.m., an observation and concurrent interview was conducted with the Maintenance Assistant (MA). The MA was observed in Resident 1's bathroom. The MA confirmed Resident 1's bathroom had peeled paint on top of the sink, damaged drywall and missing paint around the light switch, missing tiles and grout at the shower area and a patch of dry, and unpainted area on the wall around the toilet. The MA also confirmed the wall at the foot of Resident 1's bed was not painted. The MA stated this was not how the bathroom and the bedroom of a resident should look like. The MA stated Resident 1's bathroom and bedroom did not look like a homelike environment. On April 7, 2026, at 10:45 a.m., an observation and concurrent interview was conducted with the Administrator (ADM). The ADM observed Resident 1's bathroom with peeled paint on top of the sink, damaged drywall and missing paint around the light switch, missing tiles and grout at the shower area and a patch of dry, and unpainted area on the wall around the toilet, as well as the unpainted wall in Resident 1's bedroom. The ADM stated this was not OK, and Resident 1's bathroom and bedroom did not look like a homelike environment. On April 7, 2026, at 10:56 a.m., a concurrent observation and interview was conducted with Resident 1. Resident 1 was alert and oriented. Resident 1 was observed in his wheelchair, in his room. Resident 1 stated he did not like the damaged dry wall and the missing tiles from the bathroom, and the unpainted area on the wall in his bathroom and in his bedroom and stated he did not like it, it was not a homelike environment. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included (continued on next page)</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>cerebral infarction (stroke), multiple sclerosis (a disease causing vision loss, numbness, fatigue, muscle weakness), and ataxia (loss of control of bodily movements, causing uncoordinated walking, speech and hand function). On April 7, 2026, at 11:09 a.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was alert and oriented. Resident 2 was observed in his wheelchair, outside of his room (room [ROOM NUMBER]). Resident 2 stated he shared a bathroom with room [ROOM NUMBER]. Resident 2 stated his bathroom had damaged dry wall, missing tiles, chipped paint, and did not look good. The facility policy and procedure titled, Bedrooms, dated January 2025, was reviewed. The policy indicated, .All residents are entitled to clean, comfortable, safe, and homelike bedrooms.</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide specialized rehabilitative services, as ordered by the physician, for one resident (Resident 1), when it did not evaluate and treat Resident 1 for Physical Therapy (PT). This failure had the potential to result in Resident 1's difficulty in attaining and maintaining his highest practicable level of physical, mental, functional, and psycho-social well-being and to prevent and slow further decline in the resident's condition and physical function. Findings: On April 7, 2026, an unannounced visit to the facility was conducted to investigate a complaint related to administration/personnel, misappropriation of property, physical environment, quality of care/treatment and rehabilitation services. On April 7, 2026, at 10:56 a.m., a concurrent observation and interview was conducted with Resident 1. Resident 1 was alert and oriented. Resident 1 was observed in his wheelchair, in his room. Resident 1 stated he had multiple sclerosis (a disease causing vision loss, numbness, fatigue, muscle weakness). Resident 1 stated he did not have any physical therapy evaluation or treatment since his admission at the facility. Resident 1 stated he could use physical therapy to help with his condition. On April 7, 2026, at 11:23 a.m., an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 1 needed assistance with mobility, and with his activities of daily living. CNA 2 stated he did not see Resident 1 getting any PT since his admission. On April 7, 2026, at 12 p.m., an observation and concurrent interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 1 needed assistance with his mobility. LVN 1 stated he did not witness Resident 1 getting PT during his stay at the facility. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), multiple sclerosis, and ataxia (loss of control of bodily movements, causing uncoordinated walking, speech and hand function). Resident 1's physician order, dated October 30, 2025, indicated, Physical Therapy evaluation and treatment as indicated. On April 10, 2026, at 10:12 a.m., an interview was conducted with the Administrator (ADM). The ADM stated Resident 1 did not have a physical therapy evaluation or treatment since his admission at the facility. The ADM stated the physician's order for PT was not followed, and it should have been followed. The facility policy and procedure titled, Specialized Rehabilitated Services, dated December 2009, was reviewed. The policy indicated, . Our facility will provide rehabilitative services to residents. Specialized rehabilitative services include . Physical therapy . Therapeutic services are provided only upon the written order of the resident's attending physician .</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the bathroom call light was functioning for two residents who shared the same bathroom (Resident 1 and Resident 2). This failure had the potential to result in accidents or injuries to Resident 1 and Resident 2. Findings: On April 7, 2026, an unannounced visit to the facility was conducted to investigate a complaint related to administration/personnel, misappropriation of property, physical environment, quality of care/treatment and rehabilitation services. On April 7, 2026, at 10:20 a.m., an observation was conducted in Resident 1's bathroom in room [ROOM NUMBER]. The bathroom from room [ROOM NUMBER] was shared with the residents from room [ROOM NUMBER]. The bathroom had a call light with a switch, for residents' use. The call light was pressed and was observed not working (no visual or audible alert). On April 7, 2026, at 10:25 am, an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 came into Resident 1's bathroom and confirmed the bathroom call light was not working. CNA 1 stated the bathroom call light should be functioning, for the safety of the residents, to prevent falls or accidents. CNA 1 stated Resident 1 needed assistance in the bathroom, to get in and out of his wheelchair. On April 7, 2026, at 10:35 a.m., an observation and concurrent interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated Resident 1 needed assistance in the bathroom. LVN 2 observed the bathroom call light shared between room [ROOM NUMBER] and 37 and stated it was not working. LVN 2 stated every bathroom should have a working call light for the safety of the residents, so the residents can call if needed. On April 7, 2026, at 10:42 a.m., an observation and concurrent interview was conducted with the Maintenance Assistant (MA). The MA was observed in Resident 1's bathroom (also shared with Resident 2). The MA confirmed the bathroom call light was not functioning and stated it should be functioning. On April 7, 2026, at 10:45 a.m., an observation and concurrent interview was conducted with the Administrator (ADM). The ADM observed Resident 1's bathroom call light and stated the bathroom call light was not functional and it should be functional. On April 7, 2026, at 10:56 a.m., a concurrent observation and interview was conducted with Resident 1. Resident 1 was alert and oriented. Resident 1 was observed in his wheelchair, in his room. Resident 1 stated he had multiple sclerosis (a disease causing vision loss, numbness, fatigue, muscle weakness). Resident 1 stated his bathroom light was not working, and he would use it if it was working. Resident 1 stated he needed help in the bathroom. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), multiple sclerosis, and ataxia (loss of control of bodily movements, causing uncoordinated walking, speech and hand function). On April 7, 2026, at 11:09 a.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was alert and oriented. Resident 2 was observed in his wheelchair, outside of his room (room [ROOM NUMBER]). Resident 2 stated he shared a bathroom with room [ROOM NUMBER]. Resident 2 stated his bathroom call light was not working, and it would be nice if it had a functioning call light, just in case he needed to use it. Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included hereditary neuropathy (genetic disorder causing damage to nerves and leading to chronic muscle weakness), and kyphosis (poor posture - hunchback). The facility policy and procedure titled, Call System, Residents, dated September 2022, was reviewed. The policy indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times.</p>		