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	11/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation practices were followed in accordance with professional standards of practice when one large cookie sheet pan had black crusted residue. This failure had the potential to cause food-borne illnesses (stomach illness resulting from ingestion of contaminated food) in a medically vulnerable population.Findings: On September 22, 2025, at 8:57 a.m., during the initial kitchen tour with the Dietary Manager (DM), one large sheet pan was observed with black crusted residue on the edges and corners of the pan. On September 24, 2025, at 9:34 a.m., two large size sheet pans with freshly baked cookies were observed on top of the metal kitchen table. One large sheet pan was observed with black crusted residue on the edges and corners of the pan. In a concurrent interview with the cook, she stated the large sheet pans were old. She stated the large sheet pans should not have black crusted residue. She stated the black crusted residue could come off when serving food to the residents. During an interview on September 24, 2025, at 9:27 a.m., with the DM, he stated some of the pots and pans were old. He stated food residue built-up over time. He stated the crusted black residue could come off and could stick in the food when served to the residents. He stated all food equipment should be free from residue. A review of the U.S. Food and Drug Administration's (FDA) Food Code 2022, Annex 3.4-602.12, indicated, .Cooking and Baking Equipment.Food-contact equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use.A review of the U.S. FDA Food Code 2022, 4-603.12, indicated, .Precleaning of utensils, dishes, and food equipment allows for the removal of grease and food debris to facilitate the cleaning action of the detergent. Depending upon the condition of the surface to be cleaned, detergent alone may not be sufficient to loosen soil for cleaning. Heavily soiled surfaces may need to be presoaked or scrubbed with an abrasive.

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

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	11/18/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan was developed and/or initiated to address the long term use of the medication potassium chloride (potassium supplement) for one of six residents reviewed (Resident 33) for appropriate medication use.This failure has the potential for Resident 33 to not be monitored for the effectiveness and/or side effects of the medication. Findings:On September 24, 2025, Resident 33's record was reviewed. Resident 33 was admitted to the facility on [DATE], with diagnoses including hypertension (high blood pressure) and localized edema (a condition where fluid accumulates in a specific area of the body, causing swelling).The active physician orders indicated the following:-Potassium Chloride ER (extended-release) Tab to be given 40 milliequivalent (mEq- unit of measurement) by mouth one time a day for potassium supplement, date ordered June 22, 2021; and -Lasix (medication used to treat edema and hypertension by increasing urination and preventing the body from absorbing excess salt) 40 milligrams (mg- unit of measurement) by mouth one time a day for generalized edema, date ordered August 18, 2025.The document titled, Care Plan Report, dated June 19, 2024, indicated, .Focus .Lasix .Resident at risk for adverse effects .Furosemide (generic name for Lasix) is a potent diuretic (medication that increases urination) that, if given in excessive amounts, can lead to profound diuresis (excessive production and excretion of urine by the kidneys) with water and electrolyte depletion. Therefore, careful supervision is required .Goal .Resident's risk for the use .will be monitored/identified by the licensed nurse. MD (Medical Doctor) will be promptly notified .Interventions .Monitor for potential risk/effects and alert MD when indicated .There was no documented evidence of a care plan initiated and/or developed to address the use of potassium chloride ER since it was ordered on June 22, 2021.On September 25, 2025, at 9:10 a.m., an interview with a concurrent record review was conducted with the Director of Nursing (DON). The DON stated:-Resident 33 had a physician's order for Potassium Chloride ER Tab to be given 40 mEq by mouth one time a day for potassium supplement. The DON stated Resident 33 was currently on the medication Lasix and the medication potassium chloride may be an adjunct (added as a supplement) to the Lasix use. -Resident 33 did not have an active care plan on the use of the medication potassium chloride supplement.-A care plan should have been initiated and/or developed when the medication potassium chloride tablet for supplement was ordered in June 22, 2021. This care plan would include monitoring the effectiveness and/or side effects of the medication.On September 25, 2025, at 11:25 a.m., an interview was conducted with the Minimum Data Set (MDS- an assessment tool) Nurse. The MDS Nurse stated:-She was responsible for reviewing and updating the residents' care plans during the comprehensive and quarterly assessments.-The potassium chloride tablet order was probably an adjunct to the Lasix medication use. -The indication for the of potassium chloride as a potassium supplement should have been reviewed and clarified with the Resident 33's physician when they did the comprehensive and quarterly assessments. The MDS Nurse stated this was not done.-Resident 33 did not have a care plan developed and/or initiated since the medication potassium chloride tablet was ordered on June 22, 2021. The MDS Nurse stated this should have been initiated and/or developed when medication potassium chloride was ordered on June 22, 2021.The facility's policy and procedure titled, Care Plans. Comprehensive Person-Centered, dated March 2022, was reviewed. The policy indicated, .A comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan .reflects currently recognized standards of practice for problem areas and conditions .Assessments of residents are ongoing, and care plans are revised as information about the residents and residents 'conditions change .The interdisciplinary team reviews and updates the careplan .at least quarterly, in conjunction with the required quarterly MDS assessment .

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	11/18/2025

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 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 observation, interview, and record review the facility failed to ensure physician orders were followed for two of two residents reviewed (Residents 7 and 38), when: 1a. For Resident 7, the medication insulin (a medication that regulates the amount of sugar in the blood), was administered outside of the physician ordered parameter; 1b. For Resident 7, the licensed nurses did not contact the physician for blood sugar levels outside of the physician's ordered parameter; 1c. For Resident 7, the medication glucagon (a medication for emergency treatment of very low blood sugar) was administered outside of the physician's ordered parameter; 2a. For Resident 38, the medication insulin was administered outside of the physician ordered parameter; and 2b. For Resident 38, the licensed nurses did not contact the physician for blood sugar levels outside of the physician's ordered parameter. These failures had the potential for Resident 7 and Resident 38 to experience avoidable episodes of hypoglycemia (low blood sugar) and/or hyperglycemia (high blood sugar).Findings: 1a. On September 24, 2025, Resident 7's medical record was reviewed. The admission record indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (high blood sugar), long term use of insulin (medication that regulates amount of sugar in the blood), and dementia (loss of intellectual functioning). The history and physical completed by the physician on December 7, 2023, indicated Resident 7 had no capacity to make decisions. The physician order dated September 1, 2025, indicated for Resident 7, the medication insulin lispro injection solution inject 6 units subcutaneously (underneath the skin) after meals for DM (diabetes mellitus) hold if blood sugar (BS) less than 150. The MAR (medication administration record) dated for the month of September 2025, indicated the following: On September 2, Resident 7 was administered the 8 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 131, outside of the physician ordered parameters to hold if BS less than 150. On September 7, Resident 7 was administered the 8 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 144, outside of the physician ordered parameters to hold if BS less than 150. On September 8, Resident 7 was administered the 12 p.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 126, outside of the physician ordered parameters to hold if BS less than 150. On September 11, Resident 7 was administered the 8 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 143, outside of the physician ordered parameters to hold if BS less than 150. On September 13, Resident 7 was administered the 8 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 140, outside of the physician ordered parameters to (continued on next page)

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	11/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hold if BS less than 150. On September 16, Resident 7 was administered the 8 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar of 147, outside of the physician ordered parameters to hold if BS less than 150. On September 19, Resident 7 was administered the 8:00 a.m., dose of the medication insulin lispro injection solution 6 units with a blood sugar level of 117, outside of the physician ordered parameters of hold if BS less than 150. 1b. On September 24, 2025, Resident 7's medical record was reviewed. The physician order dated September 24, 2025, indicated, .insulin lispro injection solution inject per sliding scale: if blood sugar less than 70 or greater than 400 call MD (medical doctor). The care plan dated April 17, 2025, indicated, .focus.resident is at risk for hypoglycemia and hyperglycemia related to diabetes mellitus.intervention.diabetes medication as ordered by doctor .monitor/document for side effects and effectiveness.monitor for/document/report prn (as needed any sx/ss (signs and symptoms) of hyperglycemia. monitor for/document/report prn any s/sx of hypoglycemia.sliding scale as ordered. The accu-check (medical device that measures blood sugar) result dated September 16, 2025, at 16:24 p.m., indicated Resident 7 had a blood sugar of 62. This result was outside of the physician ordered parameters if BS less than 70 or greater than 400 call MD. The orders-administration note dated September 16, 2025, at 4:24 p.m., indicated no documented evidence that the physician was notified for Resident 7's blood sugar of 62. 1c. On September 24, 2025, Resident 7's medical record was reviewed. The physician order dated October 17, 2023, indicated for Resident 7, glucagon emergency injection kit 1 mg (mg-a unit of measurement) Inject 1mg subcutaneously as needed for blood sugar less than 60. The Medication Administration Record (MAR) dated September 25, 2025, at 5:09 a.m., indicated Resident 7 was administered the medication glucagon emergency injection kit 1mg for a blood sugar of 97, outside of the physician ordered parameters for BS less than 60. On September 24, 2025, at 2:46 p.m., a concurrent interview and record review was conducted with LVN 1. LVN 1 stated the facility process for administering insulin is to check the residents' blood sugar against the physician's order for insulin, and either administer or hold the insulin. LVN 1 stated Resident 7's physician order for the medication insulin lispro injection states to hold the insulin if the blood sugar is below 150. LVN 1 stated on the following days September 2, September 7, September 13, September 15, September 19, and September 23, 2025, Resident 7 's blood sugar was outside of the physician's ordered parameters and the medication insulin lispro injection should not have been administered to Resident 7. On September 25, 2025, at 9:46 a.m., a concurrent interview and record review was conducted with LVN 2. LVN 2 stated the facility process for residents with low blood sugars are to administer (continued on next page)

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	11/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucagon and notify the physician, DON and family, offer snacks to the resident and recheck the resident blood sugar after 5 minutes and monitor the resident. LVN 2 stated Resident 7's physician order for the medication glucagon was to administer when blood sugar was less than 70. LVN 2 stated on September 25, 2025, Resident 7's blood sugar was 97 and outside of the physician's ordered parameters and the medication glucagon should not have been administered. On September 25, 2025, at 10:22 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the expectations for the nursing staff were to follow the resident specific physician ordered parameters. If the residents' blood sugar is lower or higher than physician ordered parameters, the expectation is for nursing to notify the physician. The DON stated Resident 7 should not have been administered the medication insulin and the medication glucagon outside of the physician ordered parameters. The DON further stated that not following physician orders can result in undesired outcomes for the residents. 2a. On September 22, 2025, at 12 p.m., Resident 38 was observed lying in bed, awake and alert. In a concurrent interview with Resident 38, he stated he checked his own blood sugar level and self-administered the insulin. He also stated there were instances when his blood sugar was low and he would inform the nurses. He also stated the nurses would not do anything when his blood sugar was low. On September 23, 2025, at 1:08 p.m., Resident 38 was observed lying in bed, awake and alert. Resident 38 could not recall our conversation on September 22, 2025, regarding his low blood sugar. On September 25, 2025, Resident 38's record was reviewed. Resident 38 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus. The undated history and physical indicated Resident 38 did not have the capacity to make decisions. The Minimum Data Set (MDS – an assessment tool) dated July 25, 2025, indicated a BIMS (Brief Interview of Mental Status – cognitive assessment tool) score of 7 (severely impaired). The physician order dated May 25, 2025, indicated, .Insulin Aspart (a type of insulin).5 unit (sic) subcutaneously one time a day.hold if blood sugar is below 200. The Medication Administration Record (MAR) for August and September 2025 were reviewed. Resident 38 was administered Aspart insulin 5 units subcutaneously on the following dates: - August 24, 2025, with a blood sugar of 147; - August 25, 2025, with a blood sugar of 105; - August 30, 2025, with a blood sugar of 188; - September 6, 2025, with a blood sugar of 150; - September 11, 2025, with a blood sugar of 198; - September 12, 2025, with a blood sugar of 190; (continued on next page)

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	11/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- September 18, 2025, with a blood sugar of 125; - September 23, 2025, with a blood sugar of 133; and - September 24, 2025, with a blood sugar of 128. On September 25, 2025, at 9:33 a.m., a concurrent interview and record review was conducted with the Registered Nurse (RN). She stated Resident 38 had a diagnosis of diabetes and had an order for Aspart (a type of insulin), 5 (five) u (a unit of measurement) inject subcutaneously (injection into the fatty tissue beneath the skin) once a day. She stated the insulin had a parameter to hold the administration if the blood sugar is below 200. She stated Resident 38 was given insulin on the following dates: - August 24, 2025, with a blood sugar of 147; - August 25, 2025, with a blood sugar of 105; - August 30, 2025, with a blood sugar of 188; - September 6, 2025, with a blood sugar of 150; - September 11, 2025, with a blood sugar of 198; - September 12, 2025, with a blood sugar of 190; - September 18, 2025, with a blood sugar of 125; - September 23, 2025, with a blood sugar of 133; and - September 24, 2025, with a blood sugar of 128. The RN stated the licensed nurses should have held the insulin for blood sugar below 200. The RN stated Resident 38 could have experienced hypoglycemia when he received insulin with a blood sugar below 200. During an interview on September 25, 2025, at 10:05 a.m., with the DON, she stated the licensed nurses should follow the physician's order. The DON stated Resident 38 could have experienced hypoglycemia. She stated the licensed nurses should have followed the physician's order and should have held the insulin when Resident 38's blood sugar was below 200. 2b. On September 25, 2025, at 9:33 a.m., a concurrent interview and record review was conducted with the RN. She stated Resident 38 had a diagnosis of diabetes and had an order for Aspart (a type of insulin), 5 (five) u (a unit of measurement) inject subcutaneously (injection into the fatty tissue beneath the skin) once a day. She stated the insulin had a parameter to hold the administration if the blood sugar is below 200. She stated there was no documentation the licensed nurses notified the physician when Resident 38's blood sugar was below 200. She stated the standard of practice was to notify the physician if the residents' blood sugar was below the ordered parameter. During an interview on September 25, 2025, at 10:05 a.m., with the DON, she stated the expectation (continued on next page)

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	11/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was for the license nurse to notify the physician when the blood sugar was below the ordered parameter so the physician could make the necessary adjustment to prevent hypoglycemia. A review of the facility's policy and procedure titled Administering Medications, revised April 2019, indicated .Medications are administered in a safe and timely manner, and as prescribed .

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	11/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the failed to ensure, for two of two medication carts inspected for medication storage:1.Discontinued medications for Residents 7, 35, and 5, were not stored in the medication cart readily available for use; and2.Unidentified medication pills that were not in their original containers or packaging were not stored in the medication cart drawer.These failures had the potential risk for the residents to receive medications that were either discontinued or compromised. Findings:1. On September 24, 2025, at 1:03 a.m., an observation, with a concurrent interview, and record review was conducted with Licensed Vocational Nurse (LVN) 3. An inspection of the Medication Cart (MC) 1 was conducted with LVN 3. LVN 3 stated all medications stored in MC 1 were readily available for use. The following discontinued medications were observed stored in MC 1:- For Resident 5, 31 tablets of clonidine (medication used to treat hypertension) 0.2 milligrams (mg-unit of measurement) take one tablet by mouth every 12 hours for hypertension. In a concurrent interview, LVN 3 stated this medication was discontinued in December 4, 2024;- For Resident 35, 14 tablets of ibuprofen (pain medication) 400 mg take one tablet by mouth every six hours as needed for mild pain. In a concurrent interview, LVN 3 stated this medication was discontinued in February 6, 2024, and-For Resident 35, three tablets of ondansetron (medication used to prevent nausea and vomiting) take one tablet by mouth every eight hours as needed for nausea. In a concurrent interview, LVN 3 stated this medication was discontinued in April 8, 2025.LVN 3 stated these discontinued medications should not have been stored in MC 1 and readily available for use. LVN 3 stated these should have been removed from MC 1 by the licensed nurse because it was discontinued.On September 24, 2025, at 12:14 p.m., an observation with a concurrent interview and record review was conducted with LVN 2. LVN 2 stated medications stored in MC 2 were readily available for use. The following discontinued medications were observed stored in MC 2: - For Resident 7, three tablets of alprazolam (medication used to treat anxiety) 0.25 mg one tablet every six hours as needed for anxiety. In a concurrent interview, LVN 2 stated this medication was discontinued in April 8, 2025. LVN 2 stated the discontinued alprazolam medication should have been removed from MC 2 and turned in to the Director of Nursing (DON) for destruction. The facility's policy and procedure titled, Discontinued Medications, dated November 2022, was reviewed. The policy indicated, .Staff shall destroy discontinued medications or return them to the dispensing pharmacy in accordance with the facility policy .The nurse receiving the order to discontinue a resident's medication is responsible for recording the information (e.g writing discontinued date, dating and initialing MAR {medication Administration record}) and notifying the dispensing pharmacy of the discontinuation .Discontinued medications are destroyed or returned to the issuing pharmacy in accordance with facility policy and state regulations . 2. On September 24, 2025, at 1:03 p.m., an observation, with a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 3. An inspection of the Medication Cart (MC) 1 was conducted with LVN 3. LVN 3 stated all medications stored in the MC 1 were readily available for use.During the medication cart inspection, nine unidentified medication pills were found stored and scattered in the medication cart drawer next to the residents' bubble pack medications. These unidentified medication pills were variable in color and size and were not in their original container or packaging.In a concurrent interview, LVN 3 stated he was not able to identify what the nine unidentified scattered pills were. LVN 3 stated these should have been destroyed and not stored in the medication cart.On September 24, 2025, at 2:36 p.m., an interview was conducted with the DON. The DON stated the scattered unidentified medication pills should not have happened. The DON stated the scattered unidentified medication pills stored in the medication cart were not safe. The facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023 was reviewed. The policy indicated, .The facility stores all medications and biologicals in locked (continued on next page)

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	11/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	compartments under proper temperature, humidity and light controls .Medication storage .medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received .The nursing staff is responsible for maintaining medication storage and preparation areas i a safe, clean, and sanitary manner .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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	11/18/2025

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interview and record review, the facility failed to ensure the Registered Dietician (RD) conducted comprehensive nutritional assessments on-site from August 12, 2025, to September 25, 2025.This failure had the potential for the residents not to receive the correct nutritional comprehensive assessment that could result in receiving suboptimal nutrition services which could lead to decreased nutrition for vulnerable residents residing at the facility.Findings:During an interview on September 24, 2025, at 9:57 a.m., with the Dietary Manager (DM), he stated the Registered Dietician worked 100% remotely. He stated the RD would get information from the electronic medical records of the residents. He stated the RD would talk to him and the Director of Nursing (DON) over the telephone to get information regarding the residents. He stated the RD did not do any on-site visit. He stated the last on-site visit of the previous RD was on August 11, 2025.During a telephone interview with the RD, she stated she worked 100% remotely. She stated the previous RD's last day was August 11, 2025. The RD stated she started to help in July 2025. She stated she was responsible for identifying significant weight changes, notifying the Interdisciplinary Team (IDT - a group of professionals from different fields who collaborate to work toward a common goal, sharing knowledge and expertise), conduct Minimum Data Set (MDS - an assessment tool) assessments, and nutrition assessments for newly admitted residents and if there were significant changes.The RD indicated she was not aware she needed to perform a full assessment in-person. The RD stated she would review all notes in the resident's electronic record and collaborated with the nurses, the DON and the DM by talking to them on the telephone. She also stated she would talk to the DON for IDT meetings on the telephone. She stated if she had recommendations, she would put it in the nutritional risk assessment.During an interview on September 29, 2025, at 2:53 p.m., with the Administrator (ADM), he stated the facility had an RD that would come to the facility on a regular basis but quit. He stated an RD that worked 100% remotely started around mid August 2025. He stated the RD communicated with the DM and the DON via email or the telephone.The following residents were assessed by the RD remotely:- Resident 54;- Resident 55;- Resident 56;- Resident 57; and- Resident 58.A review of the facility document titled PERSONNEL MANAGEMENT, dated 2018, indicated, RESPONSIBILITIES OF THE CONSULTANT DIETICIAN.A Consultant Dietician.is a staff member who provides regularly scheduled on-premises consultation, to the Administrator, the FNS (Food and Nutrition Supervisor), the residents, and other facility personnel and staff.A review of the undated facility document received by the facility ADM from (Name of Nutrition Consulting Firm) on September 25, 2025, titled Key Responsibilities of Registered Dietician, indicated, .Ensure compliance with all applicable state and federal regulations.

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	11/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one of one resident (Resident 10) food brought from home was consistent with the pureed diet (food mashed or blended to a smooth, pudding like consistency) as ordered by the physician.This failure had the potential for Resident 10 to have a choking incident as a result of eating the food brought by the family from home.Findings:On September 22, 2025, at 12:39 p.m., during a meal observation, Resident 10 was observed in bed. A meal tray was observed on top of Resident 10's bedside table. The meal tray had a plate with a pureed diet. A banana and green grapes in a plastic container were observed on top of the bedside table. In a concurrent interview with Resident 10, he stated the fruit was brought in by his family. He stated he ate the grapes occasionally. He also stated he was not sure why he was given baby food.On September 23, 2025, at 2:45 p.m., a plastic container with green grapes was observed on top of Resident 10's bedside table. Resident 10 was not in his room.On September 23, 2025, Resident 10's record was reviewed. Resident 10 was admitted to the facility on [DATE], with diagnoses which included anxiety disorder and diabetes (high blood sugar).The history and physical dated August 22, 2025, indicated Resident was alert, cooperative and had no signs of cognitive impairment.The physician's order dated August 9, 2025, indicated, .Regular diet, pureed texture.During an interview on September 24, 2025, at 3:08 p.m., with Certified Nursing Assistant (CNA) 1, she stated when the family brought food from home, the process was to check with the licensed nurse if the resident was allowed to eat the food that the family brought from home.During an interview on September 24, 2025, at 3:18 p.m., with the Director for Staff Development (DSD), he stated the staff should check food brought by the family to ensure the resident was allowed to have them. He stated a resident on a pureed diet could have a choking incident if they ate the regular food.On September 24, 2025, at 3:25 p.m., the Registered Nurse (RN) was interviewed. She stated Resident 10's diet order was regular with pureed texture. She stated Resident 10's family must have brought in fruit when they came to visit. She stated the certified nursing assistants and licensed nurses should be checking food brought from home. She also stated Resident 10 could choke from having regular food. In a concurrent record review with the RN, she stated Resident 10 was admitted under hospice care (end of life care) from home and was on pureed diet. She stated the hospice recertification period from September 17 to November 15, 2025, indicated Resident 10 was recently downgraded from mechanical soft to pureed due to aspiration (choking) risk.During an interview on September 24, 2025, at 3:48 p.m., with the Director of Nursing (DON), she stated the staff should verify food brought from outside by a family member or a visitor and check with the licensed nurse if the food was allowed to be consumed by the resident.The facility policy and procedure titled, Foods Brought by Family/Visitors, revised March 2022, indicated, .Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents.Foods that present a potential choking hazard for residents with impaired cognitive function or swallowing difficulty are taken from the resident and returned to the family/visitor.

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	11/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nebulizer (a small device that converts liquid medication into an inhalable mist) used to administer respiratory treatment was changed after seven days, in accordance with the facility policy and procedure, for one (Resident 12) of one resident reviewed for oxygen use. This failure had the potential to result in bacterial growth that could affect the health of the vulnerable resident population.Findings: During an observation on September 22, 2025, at 11:33 a.m., Resident 12 was observed in bed, awake and alert. A nebulizer set-up was observed in a clear plastic bag, hanging on the wall. The clear plastic bag was labeled with Resident 12's name, room number and a date of 8/25. During an observation on September 24, 2025, at 10:05 a.m., a clear plastic bag was observed hanging on the wall labeled with Resident 12's name, room number and a date of 8/25. During an interview on September 24, 2025, at 10:19 a.m., with the Respiratory Therapist (RT), he stated all respiratory equipment including oxygen canula (a device used to deliver supplemental oxygen) and nebulizer set-up should be changed every week. The RT verified Resident 12's nebulizer set-up had a date of 8/25. In a concurrent record review with the RT, he stated Resident 12 had an order for nebulized treatment every four hours as needed. The RT stated the licensed nurses gave Resident 12's nebulized treatment. He stated the licensed nurse should check the date when the nebulizer set-up was last changed. He stated the licensed nurse should have changed the nebulizer set-up once a week. During an interview on September 24, 2025, at 10:33 a.m., with the Registered Nurse (RN), she stated respiratory set-up should be changed once a week. The RN stated the RT was responsible for changing all respiratory set-up but the licensed nurse who administered the nebulized treatment should check the date of the set-up before administering the nebulized treatment. The licensed nurse should have changed the nebulizer set-up once a week. During an interview on September 24, 2025, at 10:51 a.m., with the Director of Nursing (DON), she stated the RT was responsible for changing the respiratory set-up and the licensed nurse could also change the respiratory set-up. The DON stated the licensed nurse should check the date when it was last changed. The licensed nurse should have changed the nebulizer set-up according to the facility policy and procedure. On September 24, 2025, Resident 12's record was reviewed. Resident 12 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a group of lung disease that block airflow and make it difficult to breathe). The physician order dated August 25, 2025, indicated, .Albuterol Sulfate (medication used to treat and prevent narrowing of the airways) 2.5 mg (mg - a unit of measurement) Inhale orally via nebulizer every 4 hours as needed for sob (shortness of breath)/cough. The Medication Administration Record (MAR) for September 2025, indicated Resident 12 received nebulized treatments on September 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, and 21, 2025. The facility policy and procedure, titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated, .Change equipment and tubing every seven days, or according to facility protocol.

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	11/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was below five percent (%) when three medication errors out of 28 opportunities was observed for one of six residents (Resident 33) observed for medication administration.This failed facility practice resulted in a medication error rate of 10.71 percent (3 errors out of 28 opportunities) and has the potential for Resident 33 to experience the side effects of the medications not given as prescribed by the physician.Findings: On September 24, 2025, at 8:45 a.m., a medication pass observation on Resident 33 was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 was observed verifying medication with the physician's orders in the electronic Medication Administration Record (eMAR) as she prepared the following medications:- One tablet of Metoprolol (medication used to treat high blood pressure) 25 milligrams (mg- unit of measurement);- One tablet of Lisinopril (medication used to treat high blood pressure) 10 mg;- One tablet of Calcium 500 mg (calcium supplement);- One gel cap of docusate sodium (stool softener) 100 mg;- One tablet of Mirabegron Extended Release (medication used to treat overactive bladder) 50 mg;- One tablet of Ferrous sulfate (iron supplement) 325 mg;- Two tablets of potassium chloride (potassium supplement) ER (extended release) 20 mEq (milliequivalent - unit of measurement). The potassium chloride ER had a medication label instruction to give with food;- One tablet of celecoxib (pain medication) 200 mg. The celecoxib had a medication label instruction to give with food.- One capsule of gabapentin (medicating used to treat nerve pain) 300 mg;- One tablet of Dicyclomine (anti-spasmodic medication that works by relaxing muscles of the stomach and intestines to reduce cramping)) 10mg 1 tab;- One tablet of cranberry tablet (supplement) 425 mg;- One capsule of fish oil (supplement) 1000 mg; and- One capsule of acidophilus (medication used to help restore the normal balance of intestinal bacteria).On September 24, 2025, at 9:04 a.m., LVN 1 administered these medications to Resident 33. LVN 1 was observed to have administered the medications potassium chloride ER and celecoxib without food.On September 24, 2025, Resident 33's record was reviewed. Resident 33 was admitted to the facility on [DATE], with diagnoses including osteoarthritis (swelling and tenderness of one or more joints causing joint pain and stiffness), generalized abdominal pain, and Gastroesophageal Reflux Disease (GERD - happens when stomach acid flows back up to the esophagus causing a burning sensation in the chest.The active physician orders indicated the following:-Potassium Chloride ER Tab to be given 40 mEq by mouth and with food one time a day for potassium supplement, date ordered June 22, 2021;-Celecoxib Capsule 200 mg give 1 capsule by mouth two times and with food a day for pain management, date ordered July 20, 2021); and-Ferrous Sulfate Tablet 325 give 1 tablet by mouth and with food two times a day for anemia (a problem of not having enough health red blood cells to carry oxygen to the body tissues), date ordered June 22, 2021.On September 24, 2025, at 9:11 a.m., an interview was conducted with Resident 33. Resident 33 stated her last meal was at 7 AM this morning and she did not have snacks between breakfast and up until the time she took her morning medication with LVN 1 at 9:04 a.m.On September 24, 2025, at 9:14 a.m., an interview with a concurrent record review was conducted with LVN 1. LVN 1 reviewed Resident 33's physician orders for potassium chloride ER, celecoxib, and ferrous sulfate. LVN 1 stated she did not administer these medications with food to Resident 33 as ordered by the physician. LVN 1 stated Resident 33 may experience a GI (gastrointestinal) upset if these medications were taken without food. LVN 1 stated she should have administered these medications with food to Resident 33 as ordered by the physician.On September 25, 2025, at 9:10 a.m., an interview with a concurrent review was conducted with the Director of Nursing (DON). the DON reviewed Resident 33's physician orders for potassium chloride ER, celecoxib, and ferrous sulfate. The DON stated LVN 1 should have administered these medications with food as ordered by the physician. The DON stated if these medications were not administered with food, Resident 33 may experience stomach upset. The DON stated Resident 33 is at high risk of experiencing stomach upset because her diagnosis of (continued on next page)

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	11/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic abdominal pain and GERD.According to the DailyMed (web based drug information reference):- .potassium chloride capsule, extended release .DOSAGE AND ADMINISTRATION .Because of the potential for gastric irritation .should be taken with meals .;- .CELEBREX (brand name of celecoxib capsule) .Gastrointestinal Risk .CELEBREX cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration (process of open sore forming on the skin or mucous membrane), and perforation (a hole or tear on the lining of the stomach) of the stomach or intestines, which can be fatal .; and-ferrous sulfate 325 mg .DIRECTIONS .Adults and children over 12 years age .1 tablet daily preferably with a meal or as directed by a doctor .The facility's policy and procedure titled, Administering Medications, dated April 2019 was reviewed. The policy indicated, .Medications are administered in a safe and timely manner, and as prescribed .medications are administered in accordance with prescriber's orders, including required timeframe .

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	11/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 33) observed for medication pass, was free from significant medication error when the medications celexocib (pain medication), potassium chloride (potassium supplement) ER (Extended Release), and ferrous sulfate tablet supplement, were not administered with food as ordered by the physicianThis failure had the potential for Resident 33 to experience the side effects of these medications. Findings:On September 24, 2025, at 8:45 a.m., a medication pass observation on Resident 33 was conducted with Licensed Vocational Nurse (LVN) 1. Included in the morning medications prepared by LVN 1 for Resident 33 were the following medications that had an instruction to give with food:- One tablet of Ferrous sulfate 325 milligrams (mg-unit of measurement);-One tablet of celecoxib 200 mg; and-Two tablets of potassium chloride ER 20 mEq (milliequivalent - unit of measurement).On September 24, 2025, at 9:04 a.m., LVN 1 administered these medications to Resident 33 without food. On September 24, 2025, at 9:11 a.m., an interview was conducted with Resident 33. Resident 33 stated her last meal was at 7 AM this morning and she did not have snacks between breakfast and up until the time she took her morning medication with LVN 1 at 9:04 a.m.On September 24, 2025, at 9:14 a.m., an interview with a concurrent record review was conducted with LVN 1. LVN 1 reviewed Resident 33's physician orders for potassium chloride ER, celecoxib, and ferrous sulfate. LVN 1 stated she did not administer these medications with food to Resident 33 as ordered by the physician. LVN 1 stated Resident 33 may experience a GI (gastrointestinal) upset if these medications were taken without food. LVN 1 stated she should have administered these medications with food to Resident 33 as ordered by the physician.On September 24, 2025, Resident 33's record was reviewed. Resident 33 was admitted to the facility on [DATE], with diagnoses including osteoarthritis (swelling and tenderness of one or more joints causing joint pain and stiffness), generalized abdominal pain, and Gastroesophageal Reflux Disease (GERD - happens when stomach acid flows back up to the esophagus causing a burning sensation in the chest)The current physician orders indicated the following:-Potassium Chloride ER Tab 40 mEq to be given by mouth and with food one time a day for potassium supplement, date ordered June 22, 2021; -Celecoxib Capsule 200 mg give 1 capsule by mouth and with food two times a day for pain management, date ordered July 20, 2021); and-Ferrous Sulfate Tablet 325 give 1 tablet by mouth and with food two times a day for anemia (a problem of not having enough health red blood cells to carry oxygen to the body tissues), date ordered June 22, 2021.The following care plans indicated: .Resident is at risk for GI distress or bleeding related to diagnosis of GERD .Revision Date .06/7/2025 .The resident will remain free from discomfort, complications or s/sx (symptoms) related to dx (diagnosis) of GERD .Give medications as ordered. Monitor/document side effects and effectiveness . Resident is at risk for low Hgb (hemoglobin-protein found in red blood cell that carries oxygen throughout the body)- and Hct (hematocrit - percentage of red blood cells in a person's blood) decreased total body iron content below normal levels related to ANEMIA Revision Date 06/19/2025 .Give medications as ordered. Monitor for side effects, effectiveness .Resident has potential for Alteration in Comfort/Pain related to: Chronic Pain Syndrome, Positioning discomfort, Osteoarthritis .Revision Date 06/07/2025 .Administer pain medication as per orders .On September 25, 2025, at 9:10 a.m., an interview with a concurrent review was conducted with the Director of Nursing (DON). the DON reviewed Resident 33's physician orders for potassium chloride ER, celecoxib, and ferrous sulfate. The DON stated LVN 1 should have administered these medications with food as ordered by the physician. The DON stated if these medications were not administered with food, Resident 33 may experience stomach upset. The DON stated Resident 33 is at high risk of experiencing stomach upset because of her diagnosis of chronic abdominal pain and GERD.According to the DailyMed (web based drug information reference):-.potassium chloride capsule, extended release .DOSAGE AND ADMINISTRATION .Because of the (continued on next page)

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	11/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential for gastric irritation .should be taken with meals .;- .CELEBREX (brand name of celecoxib capsule) .Gastrointestinal Risk .CELEBREX cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration (process of open sore forming on the skin or mucous membrane), and perforation (a hole or tear on the lining of the stomach) of the stomach or intestines, which can be fatal .; and-ferrous sulfate 325 mg .DIRECTIONS .Adults and children over 12 years age .1 tablet daily preferably with a meal or as directed by a doctor .The facility's policy and procedure titled, Administering Medications, dated April 2019, was reviewed. The policy indicated, .Medications are administered in a safe and timely manner, and as prescribed .medications are administered in accordance with prescriber's orders, including required timeframe .

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	11/18/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the diet order was followed according to physician's order for one of 52 residents reviewed (Resident 5), when Resident 5 was observed to receive a pureed diet on September 22, 2025, during lunch.This failure had the potential to compromise Resident 5's nutritional and medical condition.Findings:On September 22, 2025, at 12:06 p.m., during meal observation, Resident 5 was observed in the dining room, lying in a Geri chair (geriatric chair - a recliner chair for individuals with limited mobility). Resident 5 was observed to have his lunch while being fed by Certified Nursing Assistant (CNA) 2. Resident 5 was observed to have a pureed diet (mashed or blended to a smooth, pudding-like consistency). In a concurrent interview with CNA 2, she stated she fed Resident 5 a pureed diet. Resident 5's meal ticket was verified with CNA 2. The laminated meal ticket indicated, .Resident's name.CCHO (Consistent Carbohydrate - diet with consistent amount of carbohydrates), regular consistency. The laminated meal ticket had Pureed, written in black marker.On September 24, 2025, Resident 5's record was reviewed. Resident 5 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing).Resident 5's Minimum Data Set (MDS - an assessment tool) indicated a BIMS (Brief Interview for Mental Status - a cognitive screening assessment tool) score of 3 (severe impairment).The physician order dated July 2, 2025, indicated, .CCHO diet, Mechanical Soft texture (a modified diet that consists of foods that are easy to chew and swallow), Regular consistency.Resident 5's Care Plan revised September 24, 2025, indicated, .Focus.Resident has alteration in nutritional status.Diet.CCHO diet, Mechanical Soft texture.Interventions/Tasks.Provide, serve diet as ordered.During an interview on September 24, 2025, at 12:33 p.m., with CNA 2, CNA 2 stated she fed Resident 5 lunch on September 22, 2025, and on September 23, 2025. CNA 2 stated Resident 5 had pureed diet on both days. CNA 2 stated on September 22, 2025, and September 23, 2025, Resident 5's laminated meal ticket had Pureed, written with black marker. She stated today (September 24, 2025) was the first time she saw Resident 5 receive a mechanical soft diet.During a concurrent interview and record review on September 24, 2025, at 12:40 p.m., with the Dietary Manager (DM), he stated he changed the laminated meal ticket for Resident 5 on September 23, 2025. He stated a staff member informed him Resident 5's laminated meal ticket had a smear from a black marker. He stated Resident 5 had an order for a CCHO, mechanical soft diet. The DM stated he was not aware Resident 5 was receiving a pureed diet. He stated Resident 5 should not have received a pureed diet when Resident 5's diet was changed to mechanical soft on July 2, 2025.During a concurrent interview and record review on September 24, 2025, at 2:39 p.m., with the Director of Nursing (DON), she stated Resident 5 had a diet order of CCHO diet, mechanical soft. She stated the expectation was for Resident 5 to receive the correct diet. She stated the nurses should be checking the resident's diet order list before the meal trays were passed. The DON stated the physician's order should be followed. She also stated she expected the DM to supervise the kitchen staff to ensure the residents were receiving the diet ordered by the physician.The facility policy and procedure titled, Therapeutic Diets, dated October 2017, indicated .Therapeutic diets are prescribed by the attending physician to support the resident's treatment.and in accordance with his/her goals.A therapeutic diet must be prescribed by the resident's attending physician.A therapeutic diet is considered a diet ordered by a physician.as part of treatment for a disease or clinical condition.

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	11/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow infection control measures for one of five residents reviewed for infection control (Resident 3) when one staff member was observed providing care for a resident (Resident 3) on Enhanced Barrier Precautions (EBP - measures used to reduce and prevent infections) without wearing recommended Personal Protective Equipment (PPE). This failure had the potential to result in spreading infection to a vulnerable resident population. On September 25, 2025, at 9:04 a.m., Licensed Vocational Nurse (LVN) 3 was observed entering Resident 3's room and handling her feeding tube (a tube inserted in the stomach, used to deliver nutrition for residents who cannot eat). LVN 3 was observed not wearing appropriate PPE (gown) when handling the feeding tube of Resident 3. An isolation cart was observed outside the room of Resident 3, with PPE readily available for staff to use (including gowns), and a posted sign indicating Resident 3 was on EBP.In a concurrent interview, LVN 3 stated Resident 3 was on EBP precautions, and she should have worn a protective gown when disconnecting the feeding tube of Resident 3. LVN 3 stated the PPE was needed to prevent infections.On September 25, 2025, at 9:22 a.m., the Director of Staff Development (DSD) was interviewed. The DSD stated LVN 3 should have worn appropriate PPE (gown) when handling the feeding tube of Resident 3, who was on EBP precautions. The DSD stated the gown was needed to prevent cross-contamination due to exposure to bodily fluids.Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing), gastrostomy (a surgical procedure that creates an opening in the stomach through the abdominal wall), and dementia (decline in mental capacity).The physician's order dated July 9, 2025, indicated, .Enhanced Bariier (sic) precautions related medical device - G-tube.The care plan for Resident 3, revised on January 13, 2025 indicated, .Enhanced Bariier (sic) precautions related medical device - G-tube. PPE: Gowns and Gloves during care . A review of the facility policy titled, Enhanced Barriers Precautions, revised December, 2025, indicated, .Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents.Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities .Enhanced barrier precautions apply when .A resident .has a wound or indwelling medical devices .Indwelling medical devices include .feeding tubes .EBPs employ targeted gown and glove use .