STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555089	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows Ridge Care Center	1700 E Washington Street Colton, CA 92324

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** 45388 Based on interview and record review, the facility failed to ensure supervision, monitoring, and implementation of interventions were enforced for one of three sampled residents (Resident 1) when Resident 1's whereabouts were not monitored and documented in accordance with the physician's orders and care plan after Resident 1 had an altercation with another resident on June 11, 2024. This failure had the potential for Resident 1 to have an increased risk of further altercation which could place him at risk of injuries and bodily harm. Findings: During a review of Resident 1's Admission Record, (contains demographic and medical information), indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest task), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1's physician order, dated November 13, 2023, it indicated, . Monitor resident whereabouts every 2 hours for aggressive behavior . During a review of Resident 1's clinical record titled, Licenses Nurses Note, dated June 11, 2024, it indicated, .PT (patient) got into a physical altercation with another resident. PT struck another pt in the left eye . During a review of Resident 1's Care plan for Altered behavior patterns related to combativeness and aggressiveness, revised on June 11, 2024, it indicated, Interventions: .Monitor resident's location and activity every two hours to prevent altercations with other Nurse/Residents . During a review of Resident 1's Medication Administration Record (MAR- a document to keep precise records of all medications and treatments a patient receives) for the month of June 2024, it indicated monitoring for whereabouts were not conducted and documented on the following dates and times: a. June 13, 2024, at 8:00 PM (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	b. June 13, 2024, at 10:00 PM c. June 19, 2024, at 6:00 PM d. June 19, 2024, at 8:00 PM e. June 19, 2024, at 10:00 PM During a concurrent phone interview and record review with the Director of Nursing (DON), on June 25, 2024, at 3:33 PM, the DON reviewed Resident 1's MAR for June 2024 and was unable to find documentation that the monitoring for Resident 1's whereabouts was conducted on June 13, 2024, at 8:00 PM, June 13, 2024, at 10:00 PM, June 19, 2024, at 6:00 PM, June 19, 2024, at 8:00 PM, and June 19, 2024, at 10:00 PM. The DON acknowledged the orders were not followed and stated it should have been. During further phone interview and record review, on June 25, 2024, at 3:37 PM, with the DON, the facility's policy and procedure (P&P) titled, Resident-to-Resident Altercations, dated September 2022, was reviewed. The P&P indicated, .g. document in the resident's clinical record all interventions and their effectiveness . The DON stated the policy was not followed and should have been. The DON further stated it was important to know where Resident 1's whereabouts were to prevent further altercations with other residents.