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	09/25/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on observation, interview and record review, the facility failed to ensure services were provided in accordance with resident needs and safely for one of 3 Residents (Resident 1) when: 1.Resident 1 acquired an open wound to right hand pinkie finger. 2.No wound dressing as ordered noted on pinkie finger open wound. 3.No wound care treatment as per Treatment Record for September 23, 2024. This failure resulted in a clinically compromised resident, (Resident 1) health and safety at risk, when the developed in facility and wound was exposed with possibility for infection. Findings: During review of Residents 1 ' s Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included: enterocolitis due to clostridium difficile (disruption of normal bacteria in colon from antibiotics causing diarrhea), mononeuropathy (compression of nerve, cause loss of movement/sensation), muscle weakness, abnormal posture, dysphagia (difficulty swallowing), protein calorie malnutrition, dystonia (involuntary muscle contractions). During an observation on September 24, 2024, of Resident 1, Resident 1 right hand pinkie finger open wound with blood smearing noted in between pinkie and ring fingers and no wound dressing as ordered. During a record review of Resident 1 ' s medical records, reviewed and verified the following: 1. Wound Risk Assessment: dated July 03, 2024=Score 21 and July 10, 2024= Score 20 .High Risk skin breakdown. 2. Wound Management September 18, 2024, pinkie right finger open wound . 3. Order: September 18, 2024, at 12:33 Moisture Associated Skin Damage (MASD) right Pinkie everyday shift for skin management, cleanse with NS, pat dry apply Xeroform (yellow petroleum gauze to cover and protect wounds), cover with foam dressing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reassess in 30 days. 4. Treatment Administration Record (TAR) for September 2024: (MASD) Right Pinkie everyday shift for skin management. Cleanse with Normal Saline, pat dry, apply Xeroform, cover with foam dressing. Reassess in 30 days. (Missing wound treatment on September 23, 2024. 5. Careplan: Altered skin integrity with open wound .5th finger pinkie right hand, interventions: administer treatments as ordered .may have hand roll on right hand with therapy, every shift assessment to determine skin status report. Date initiated September 19, 2024. (Careplan has no resident refusals of hand rolls, as per interviews with staff). During an observation and interview in resident 1 ' s room at bedside on September 24, 2024, with the Certified Nursing Assistant (CNA 1), CNA1 states, Resident 1 has the rolls in the hand, we tell her at least for one hour but she cries to take them off. When asked, did she have a wound dressing on pinkie finger? CNA states, no, but they did the dressing yesterday, no she didn ' t have the dressing on her pinkie today, I didn ' t tell the nurse because they do the treatments daily. During an observation and interview in resident 1 ' s room at bedside on September 24, 2024, with the License Vocational Nurse (LVN 1), states, I ' m doing wound treatments today, the treatment nurses are not in today. Resident 1 is supposed to have Xeroform on the wound with a dressing. I can see the right pinkie finger is supposed to have a dressing on it and does not, I ' m not sure why she doesn ' t. She did have treatment yesterday. Her wounds are right pinkie and an unstable to coccyx. During an interview on September 24, 2024, with the Director of Nursing (DON), DON states, The open wound to pinkie finger started this month, just a few days ago. Based on her comorbidities she is a high risk for skin breakdown, she has an open coccyx wound. (Acknowledgement of the pinkie finger open wound should have a dressing and was not aware of the blood in between fingers). States will have to educate staff on this. During an interview on September 24, 2024, with the Administrator (Admin), states, The open pinkie finger wound, it should have had a dressing as per the order. The nurse should have been notified by CNA staff of open wound with no dressing on. During a review of the facility ' s policy and procedure titled, Wound Care revised March 2023, the policy and procedure indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Reporting; report other information in accordance with the facility policy and professional standards of practice. During a review of the facility ' s policy and procedure titled, Prevention of Pressure Injuries revised March 2023, the policy and procedure indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific factors .1. Keep skin clean and hydrated.