

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Meadows Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that appropriate procedures were followed after an unwitnessed fall of one of four sampled resident (Resident 1). There was no documentation of the fall, physician notification, and no indication that Resident 1 was monitored following the incident.</p> <p>This failure had the potential for Resident 1's overall medical condition to decline and go undetected by the facility.</p> <p>Findings:</p> <p>During a review of Residents 1's (R1) admission Record (general demographics), the document indicated R1 was admitted to the facility on [DATE], with diagnoses that included orthopedic after care, (period following surgery or treatment where patient receives ongoing care to receive to support recovery and healing), fracture tibia and fibula (lower leg fracture), abnormality of gait and mobility (deviation from a normal walking pattern), type 2 diabetes mellitus (body has trouble controlling blood sugar), hyperlipidemia (high levels of fat in the blood), kidney disease (damage to the kidneys), hypertension (high blood pressure), syncope (fainting spell).</p> <p>During an interview with R1 on May 28, 2025, at 1:15 PM, R1 stated call lights were not being answered; he needed to wait for one hour or even longer at times. R1 stated , he called during the night and waited for hours for someone to empty his urinal. He got up, slipped, and fell in the process. Shortly after he fell, a Licensed Vocational Nurse 1 (LVN1) came to his room to answer the light and saw his wheelchair had fallen off the floor. R1 told LVN 1 that he has been calling for assistance and nobody came. R1 told LVN 1 that he slipped and fell on the floor. R1 further stated, I'm not sure if the nurse documented that I fell that night. I don't think she called my doctor to let him know that I fell.</p> <p>During an interview with LVN 2 on May 28, 2025, at 2:10 pm, LVN 2 stated LVN 1 mentioned to him that R1 fell during her shift and did not sustain any injury. R1 also made LVN 2 aware that he had a fall incident during the night. When HFEN asked LVN 2 if there was a change of condition notification (COC), vital signs, neuro checks done by LVN 1, LVN 2 stated that he was not sure since it did not happen on his shift. LVN 2 stated there should have been a COC notification to primary physician, monitoring of R1 post fall, and the incident should have been documented.</p> <p>(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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview with the Registered Nurse (RN 1) on May 28, 2025, at 2:25 pm, RN1 stated there was no COC notification and no documentation of the fall incident on the progress notes for R1. When RN1 was asked if there should have been a COC notification and monitoring done after the fall incident, RN1 stated documentation should have been done according to the facility's policy. The facility could not provide documentation that a COC was completed which includes situation (change in condition, symptoms, or signs observed), background (diagnosis, medication alerts, vital signs, mental status), appearance, review, and notification information or that the facility was monitoring for medical changes after this fall.</p> <p>During a continued interview with LVN 2, in the presence of RN 1 and the Director of Nursing (DON), on May 28, 2025, at 3:15 PM, DON stated she was not aware about R1's fall incident. LVN 2 stated LVN 1 reported to him R1 had an unwitnessed fall when he came to work that morning. RN 1 also stated there was no documentation of the fall incident and COC notification was not completed. The DON stated LVN 1 should have documented the incident, completed the COC, notified the physician, and monitored R1 after the fall incident. DON stated that she will follow up on it.</p> <p>The facility policy and procedure titled Changes in Residents Condition or Status revised March 2023, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident right, etc.). 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): a. accident or incident involving the resident 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather pertinent information for the provider, including (for example) information prompted by the interact SBAR Communication Form. RN1 and DON stated there should have been a COC notification and documentation of the fall incident.</p>		