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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows Ridge Care Center	1700 E Washington St 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 0760 Level of Harm - 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 interview and record review, the facility failed to ensure prescribed medication was administered in accordance with the physician's orders for one of four sampled residents (Resident 1) when Resident 1 had an order to received Phenytoin (medication for seizures - a sudden movement of electrical activity in the brain causing shaking of the limbs and stiffening of the body) and was not administered from June 7, 2026, to June 17, 2026 (a total of 19 doses). This failure resulted in Resident 1 being transferred to an acute care hospital after experiencing seizure activity. During a review of Resident 1's Face Sheet (contains medical and demographic information), the Face Sheet, indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included epilepsy (a brain disorder that causes repeated seizures), hemiplegia (complete loss of movement on one side of the body), hemiparesis (muscle weakness on entire side of the body) and hypertension (elevated blood pressure).During a review of Resident 1's Order Summary Report, dated June 2, 2026, the Order Summary Report indicated Resident 1 had an order for, Phenytoin capsule 100 MG (milligram - unit of measurement) Give 1 capsule by mouth to be given at 9:00 AM, 1:00 PM and 5:00 PM, for seizures.During an interview on July 1, 2026, at 2:05 PM, with Licensed Vocational Nurse 1 (LVN 1), when asked if LVN 1 administered Phenytoin Sodium Extended Oral Capsule 100 MG to Resident 1 on June 17, 2026, LVN 1 stated, That is the only medication I did not give her because the bubble pack (a prepared sheet with seal bubbles containing individual doses of medications, organized by days) was empty.During an interview on July 1, 2026, at 2:15 PM, with LVN 2, LVN 2 stated there were no Phenytoin capsules in Resident 1's bubble pack for a couple of days and she faxed the order to the pharmacy for refill more than once because the medication was not available in the medication cart. LVN 2 further stated, I did not call the pharmacy to follow up about the medication because I always thought the pharmacy would deliver the medication. LVN 2 could not provide a specific date when the order for Phenytoin was faxed to the pharmacy and stated she (LVN 2) did not remember if she told any staff to follow up.A review of Resident 1's Medication Administration Record (MAR [a legal document used by healthcare professionals to track exactly what medication a patient receives, when it was given, and who administered it]), for June 2026, indicated Phenytoin Sodium Extended Oral Capsule 100 MG capsule was not administered for the following times:1) June 7, 2026, at 9:00 AM, 1:00 PM and 5:00 PM2) June 8, 2026, at 9:00 AM and 5:00 PM3) June 9, 2026, at 9:00 AM and 1:00 PM4) June 11, 2026, at 5:00 PM5) June 12, 2026, at 9:00 AM and 5:00 PM6) June 15, 2026, at 9:00 AM, 1:00 PM and 5:00 PM7) June 16, 2026, at 9:00 AM, 1:00 PM and 5:00 PM8) June 17, 2026, at 9:00 AM, 1:00 PM and 5:00 PMDuring a concurrent interview and record review on July 1, 2026, at 2:30 PM, with the Director of Nursing (DON), Resident 1's MAR for the month of June 2026, was reviewed. The DON stated, on June 17, 2026, LVN 2 reported that Phenytoin Sodium Extended Oral Capsule 100 MG for Resident 1 was not available on June 17, 2026. The DON acknowledged medication administration for Resident 1 was not administered for eight days (19 doses). The DON further stated medications must be available for residents, and if they are not, the pharmacy is contacted immediately for delivery with the physician's orders.During an interview on July 1, 2026, at 3:02 PM, with the Pharmacist (Pharm) from [Name of Pharmacy], the Pharm stated that nine capsules of Phenytoin 100 (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 0760 Level of Harm - Actual harm Residents Affected - Few	mg-a threeˆday supply-were delivered to the facility on June 2, 2026, for Resident 1. The Pharm stated that on the same day, she contacted LVN 2 and requested that the facility obtain clarification from Resident 1's physician, as Resident 1 was also receiving an anticoagulant that could reduce the effectiveness of Phenytoin. The Pharm further explained that because the facility did not provide the required clarification before June 18, 2026, the pharmacy did not issue a refill until that date, when the facility contacted the pharmacy with Resident 1's physician's clarification.A review of Resident 1's clinical record, COC (Change in Condition) /INTERACT ASSESSMENT FORM (SBAR - Situation Background Assessment Recommendation, a communication tool used by nurses to share vital information during a patient's change of condition or a sudden decline)], dated June 17, 2026, indicated, . NURSING NOTES 1. Licensed Nurse Note. 1550 (3:50 PM) Resident noted with petite mal (brief, sudden lapses of consciousness) seizure. Resident noted with second petite mal seizure at 1940 (7:40 PM) .BP (Blood Pressure) 162/111 (normal range 120/80) MD (Medical Doctor) made aware with new order to DC (discharge) resident to [Name of hospital] for further eval (evaluation).During a record review of the facility's policy and procedure (P&P) titled, Administering Medications indicated, Policy Statement Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns .