

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/29/2026
NAME OF PROVIDER OR SUPPLIER Meadows Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to maintain accurate records of destroyed medications when nine (9) medications that were disposed were found with missing witness signature from the second licensed nurse for one of one sampled Medication Disposition Record/Pass Log (document used to record the destruction of a medication for tracking purposes). This failure had the potential to have prescription medication available for staff use. Findings: During a concurrent interview and record review on January 28, at 12:09 PM, with the DON and Registered Nurse (RN) Supervisor the Medication Disposition Record/Pass Log for month of January was reviewed. The Medication Disposition Record/Pass Log indicated the following: 1. nine (9) missing witness signatures of a second licensed nurse. The DON and RN Supervisor acknowledged the medication disposition record/pass log was not complete due to the missing witness signatures of a second license nurse. During a concurrent interview and record review on January 28, 2025, at 12:49 PM, with the DON facility's Policy and Procedure (P&P) titled, Disposal of Medication and Medication-Related Supplies, dated January 2025 was reviewed. The P&P indicated, .C. Non-controlled medication destruction occurs in the presence of two licensed nurses. D. The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form. 6. signatures of witnesses. The DON stated the P&P was not followed because it was missing the second signature of a licensed nurse.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555089	Facility ID: 555089
		If continuation sheet Page 1 of 12

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 follow proper sanitation and food safety practices to prevent foodborne illness when:1a. There were three clean dishes found to have green and brown food debris, brown grease buildup, remnants of lettuce leaf, and crumbs inside it, when stored under a food prep table in the kitchen.1b. A storage shelf under a food prep table had a white dried substance and greasy black substance with food crumbs on it where clean dishware was kept.2. Eight (8) plastic cups containing a white colored liquid which resembled milk were found in the refrigerator with no date label. These failures had the potential to result in food contamination and foodborne illness to a population of 84 medically compromised residents who reside in the facility.Findings: 1a. During a concurrent observation and interview on January 26, 2026, at 8:30 AM, inside the facility's kitchen, with Consultant Registered Dietician 1 (CRD 1), there were three aluminum dishes found on a shelf under a food prep table which had green and brown food debris, brown grease buildup, remnants of lettuce leaf, and crumbs inside it. The CRD 1 stated the dishes under the food prep table were all clean and were used for cooking. CRD 1 observed dishes with the food debris, crumbs, and grease buildup and stated it was not acceptable for clean dishes to be dirty and that staff was expected to ensure clean dishes were kept clean.1b. During ongoing observation and interview on January 26, 2026, at 8:34 AM, inside the facility's kitchen, with the CRD 1, a food prep table was observed to have a shelf which had a white dried substance and greasy black substance with food crumbs on it. Multiple clean dishes were stored on this shelf. The CRD 1 stated staff were supposed to keep the shelves clean where dishware was kept.During a concurrent interview and record review on January 29, 2026, at 11:25 AM, with the facility's CRD 1, CRD 1 and Dietary Service Supervisor (DSS), the RD stated kitchen staff were supposed to clean the kitchen daily and document the cleaning on a form titled, Dietary Cleaning Schedule. CRD 1 provided the Dietary Cleaning Schedule, for January 1, 2026, through January 29, 2026 (date of interview). The DSS stated staff were supposed to sign for each cleaning task on the cleaning schedule once the cleaning was completed.During a concurrent interview and record review on January 29, 2026, at 11:26 AM, with CRD 1 and the DSS, the facility documents titled, Dietary Cleaning Schedule, dated January 1, 2026, through January 29, 2026, were reviewed. It indicated the following, -Area must be clean by the end of the shift. -Please keep ALL areas clean daily, and plan to deep clean on the days assigned to the dietary personnel above. The document had tasks for cleaning which included but were not limited to, .prep area, spice/condiment shelves; vents/hood; oven/toaster; .Stove; can opener/slicer; microwave, blender; area around the steam table including shelves; stove, around the stove, top shelves; mixer, food processor; utensil drawers, bottom shelves, knife holder; refrigerator/dispose of leftovers; dishwashing racks, chemical area; food prep area, including bottom shelves, floor, and floor corners. Upon further review, the document was completely blank and did not include any documentation to indicate cleaning was conducted on 12 out of 28 days in January 2026. Furthermore, an additional four (4) days had only partial documentation regarding completion of the assigned daily completion tasks. In total 16 out of 28 days in January 2026, had either no documented cleaning or only partial completion of daily cleaning tasks. Both CRD 1 and the DSS acknowledged the Dietary Cleaning Schedule, dated January 1, 2026, through January 29, 2026, had 12 days with no documentation that kitchen cleaning was completed and four (4) days with only partial cleaning documented. The CRD 1 and DSS stated they did not know why the cleaning log was not completed. The facility was unable to provide any other evidence that the kitchen was cleaned in the frequency and manner as indicated in their policy and procedure.During a review of the facility's policy and procedure (P&P) titled, Cleaning Schedule, undated, the P&P indicated, All areas and equipment in the kitchen should be cleaned daily. The assigned dietary personnel will deep clean the area equipment assigned for them that day using the dietary cleaning schedule.Dietary cleaning schedule has daily (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tasks for dietary personnel based on shift and position. The assigned dietary personnel will complete the task assigned by the end of the shift and initial on the dietary cleaning schedule. Dietary service supervisor will initial after each shift to make sure the assigned area and equipment has been cleaned. During a review of the facility's P&P titled, Sanitizing Equipment and Surfaces, undated, the P&P indicated, .6. Dietary staff should ensure that all equipment, shelves, serving utensils, and surface areas are clean and in good condition. 2. During a concurrent observation and interview on January 26, 2026, at 8:40 AM, in the facility's kitchen, with CRD 1, eight (8) plastic cups full of white liquid which resembled milk was stored in a refrigerator with no date or label. CRD 1 stated the cups were full of milk products and were supposed to be dated when placed in the fridge. CRD 1 further stated she was not sure of why there were cups of milk in the fridge which were undated and she was unsure when they were placed in the fridge or when they were prepared. During a review of the facility's P&P titled, Dating and Labeling, undated, the P&P indicated, To ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. 7. Staff should be trained on the importance of food labeling and proper storage procedures to maintain food safety.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure proper and safe infection control practices were followed when: 1. Resident 7's oxygen nasal cannula tubing (device used to deliver oxygen into the nose via a tube) was found unlabeled and undated per facility's policy and procedure (P&P). 2. One laptop mounted to an Intravenous (IV) cart (a mobile cart used by licensed nurses to store and transport medication and supplies) was found visibly soiled, with dried white substance on it, on unit one outside nursing station. 3. Resident 11's Enhanced Barrier Precautions (EBP—an infection control guideline that requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading infectious diseases) protocol were not followed in accordance with facility's P&P. 4. On January 28, 2026, Licensed Vocational Nurse 3 (LVN3) was observed entering the room of Resident 32, who was on EBP precautions, without wearing the required personal protective equipment (PPE) and performing a blood glucose check. These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasite) to 83 medically compromised residents and staff in the facility. Findings: 1. During a review of Resident 7's admission Record (contains medical and demographic information), the admission Record indicated Resident 7 was admitted to the facility on [DATE] with the diagnoses which included heart failure (the heart doesn't pump enough blood to meet the body's needs), shortness of breath (sensation of being unable to breathe normally), Diabetes Mellitus (difficulty in blood sugar control). During a review of Resident 7's Physician Order dated October 05, 2025, the Physician Order indicated, Change oxygen tubing q [every] night shift, on Sunday and PRN [as needed]. During an observation on January 26, 2026, at 11:08 AM, in hallway of unit 3, Resident 7 was observed independently propelling himself down unit three hallway in his wheelchair. There was an oxygen nasal cannula tubing not in use by Resident 7, attached to an oxygen concentrator (device that provides supplemental oxygen). The oxygen nasal cannula tubing was unlabeled and undated. During a concurrent observation and interview on January 26, 2026, at 11:08 AM, with a Licensed Vocational Nurse 1 (LVN 1), in the hallway of unit three, LVN 1 inspected Resident 7's oxygen nasal cannula tubing. LVN 1 stated the oxygen nasal cannula tubing was not labeled and should have been labeled and dated. During a concurrent interview and record review on January 28, 2026, at 10:58 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Oxygen Administration, dated January 2026 was reviewed. The P&P indicated, . 10. The date, time and initials should be noted on oxygen equipment when it is initially used and then when changed. The DON stated the P&P was not followed and should have been for infection control prevention. 2. During a current observation and interview on January 28, 2026, at 9:28 AM, with Registered Nurse (RN) Supervisor 1, on unit one outside nursing station, a laptop mounted to an IV cart was found visibly soiled, with dried white substance. RN Supervisor 1 acknowledged the laptop was dirty with white substances, RN Supervisor 1 stated the facility's expectation is for resident care equipment to be cleaned to prevent potential cross contamination. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on January 28, 2026, at 11:05 AM, with the DON, the facility's Policy and procedure (P&P) titled, Cleaning and Disinfecting of Resident Care Items and Equipment, dated September 2022, was reviewed. The P&P indicated, . Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected.c. Non-critical resident care items include bedpans, blood pressure cuffs, crutches and computers. The DON confirmed that the P&P was not followed and stated that adherence is critical due to the increased risk for infection within the resident population. 3. During a review of Resident 11 's admission Record the admission Record indicated Resident 11 was admitted to the facility on [DATE] with the diagnoses which included, Chronic Obstructive Pulmonary Disease (COPD- a progressive lung disease that blocks airflow, making it hard to breathe), Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Epilepsy (a brain condition that causes recurring seizures). During a review of Resident 11's Physician Order dated January 27, 2026, the Physician Order indicated, EBP-Enhanced Barrier Precautions R/T [related to] G TUBE (gastrostomy- a tube placed through the stomach to receive nutrients and medications). During an observation on January 28, at 5:22 AM, inside Resident 11's room, observed LVN 2 administering the following medications via Gastrostomy tube; Hydrocodone 10 milligrams (MG&mdash;a unit of measurement) /Acetaminophen 325 MG (used to manage moderate to severe pain) to Resident 11 on EBP without wearing the required protective gown. During an interview on January 28, 2026, at 5:35 AM, with LVN 2 outside Resident 11's room LVN 2 confirmed and verified, Resident 11 is on EBP related to resident's g tube. LVN 2 confirmed that she did not wear required protective gown during her medication administration. LVN 2 acknowledged that she did not follow the facility's P&P for EBP. During a concurrent interview and record review on January 28, 2026, at 10:16 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated June 2025, was reviewed. The P&P indicated, .2 . EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.a.Gloves and gowns are applied prior to performing high contact resident care activities.3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include.g. device care or use(central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc).5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The DON stated the policy was not followed and further state it is important for the P&P to be followed to prevention the spread of infectious diseases. 4. On January 28, 2026, at 5:19 AM, Licensed Vocational Nurse 3 (LVN3) donned gloves and mask, entered Resident 32's room and performed a blood glucose check to Resident 32 at bedside. Resident 32 was on Enhanced Barrier Precautions - Gown and Gloves Required for Room Entry as indicated by the signage posted above the resident's bed. LVN 3 did not wear a gown prior to entering the room as required and proceeded to provide care without wearing the gown. During an interview on January 28, 2026, at 5:30 AM, LVN 3 stated, I forgot to put on the gown before going in. I always wear a gown for EPB patients, I just forgot this time. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 32's Face Sheet (lists resident demographic information) indicated Resident 32 was admitted at the facility on April 19, 2023, with diagnoses which include paraplegia (paralysis, or significant impairment, of the lower half of the body, affecting the legs and sometimes the trunk), neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord or nerve problems), retention of urine (inability to fully empty the bladder, resulting in urine building up inside). A review of Resident 32's Physician's Order dated October 2, 2025, indicated, ENHANCED BARRIER PRECAUTIONS related to Foley Catheter. During an interview with facility's Infection Preventionist (IP) on January 28, 2026, at 10:26 AM, the IP stated her expectations are that staff follow facility's Infection Prevention Policies and Procedures at all times. The IP stated LVN 3 should have used the available PPE, including the gown, before performing blood glucose check for Resident 32 to decrease the risk of transmission of multidrug-resistant organisms (MDROs) to other residents and staff. During a concurrent interview on January 28, 2026, at 11:22 AM with the Director of Nursing (DON), and record review of the facility's Infection Control Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated June 5, 2024, the P&P was reviewed. The P&P stated, 1. Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-dmg resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 2.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk . 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted outside of resident's room or head of the bed indicating the type of precautions and PPE required. 11. PPE is available outside/inside of the resident rooms. 13. Colonized residents are at risk of developing invasive infections and clinical diseases and can transmit to other residents depending on the situation and recommendation from your local Public Health, based on these guidelines and facility discretion the implementation of EBPs or CPs (Contact Precautions) will apply. The DON acknowledged the facility's EBP P&P was not followed and stated his expectations are that staff must adhere to all facility's Infection Prevention and Control Policies and Procedures, including the Enhanced Barrier Precaution P&P, to decrease the risk of transmission of multidrug-resistant organisms (MDROs) to other residents, staff and visitors. The DON further stated that this failure to follow PPE requirements is not in accordance with facility's policy and federal regulations for infection prevention and control.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's right were followed for one of three sample residents (Resident 7) when Resident 7 was administered lorazepam (medication used to treat short-term anxiety, panic attacks, and sleep problems) without being informed in advance of the risks and benefits of the medication, the treatment alternatives or other options. This failure resulted in Resident 7 not being fully informed about the care and treatment provided. Findings: During a review of Resident 7's admission Record (contains medical and demographic information), the admission Record indicated Resident 7 was admitted to the facility on [DATE] with the diagnoses which included Anxiety (a feeling of fear, dread, or uneasiness,), heart failure (the heart doesn't pump enough blood to meet the body's needs), shortness of breath (sensation of being unable to breathe normally), and diabetes (difficulty in blood sugar control). During a review of Resident 7's Physician Order dated November 18, 2025, the Physician Order indicated, Lorazepam 0.5 milligrams (MG-a unit of measurement) give one tab by mouth every four hours as needed for anxiety. During a concurrent interview and record review on January 29, 2026, at 11:42 AM, with the Case Manager, Resident 7's informed consent form for psychotherapeutic drugs was not signed by Resident 7 or Resident 7's Physician. The Case Manager stated, It does not appear he received informed consent prior to the start of lorazepam; I am unable to find a signed informed consent in Resident 7's chart. During a concurrent interview and record review on January 29, 2026, at 1:12 PM, with Resident 7, in Resident's 7 room. Resident 7 stated his provider did not discuss the side effects, risk and benefits of his anti-anxiety medications with him. Resident 7 stated he's been on the medication for a while. During a concurrent interview and record review on January 29, 2026, at 1:33 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Psychotherapeutic Drugs Informed Consent, dated January 2020 was reviewed. The P&P indicated, .Purpose: To ensure that residents and /or their representatives are fully informed of the benefits, risk, frequency/duration, possible side effects and alternative approaches before initiating the administration of psychotherapeutic drugs. 4. The prescriber must sign an informed consent form after explaining all necessary information to the resident or their representative. 6. The resident and /or their representative have the right to: accept, decline, or revoke consent at any time. 10. The informed consent form shall be maintained in the resident's clinical record. The DON stated the P&P was not followed and Resident 7 should have received informed consent prior to medication administration and documentation should be in the resident's chart.		

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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 provide supervision to one of one resident (Resident 56) when on January 25, 2026, Resident 56 left the facility without staff being aware. Resident 56 was found down the street from the facility in a parking lot near a gas station. This failure had the potential to result in harm to Resident 56 who was at risk for injuries. Findings: During a review of Resident 56's Face Sheet (contains medical and demographic information), the Face Sheet indicated Resident 56 was initially admitted to the facility on [DATE], with diagnoses which included aphasia (a language disorder that affects the ability to speak, understand, read and/or write), epilepsy (seizure disorder), anxiety disorder (a condition characterized by excessive fear of or apprehension about real or perceived threats), schizoaffective disorder (a mental health condition characterized by the combination of schizophrenia symptoms [e.g., hallucinations, delusions, disorganized speech] and mood disorder symptoms), and leukemia (cancer of the blood). During a review of Resident 56's care plan (an individualized plan for the medical care of a resident), titled, Risk for wandering/elopement dx [diagnosis] of anxiety, schizoaffective disorder. episodes of elopement, poor safety awareness, impaired cognition, dated May 16, 2025, the goal of the care plan indicated, The resident will not leave facility unattended and the Resident's safety will be maintained. During an observation on January 26, 2026, at 10:31 AM, Resident 56 was observed to be inside his room with a 1:1 (one on one) staff member (a safety intervention where a dedicated staff member remains within arm's reach or in constant line-of-sight of a single patient) at his bedside. During an interview on January 28, 2026, at 1:29 PM, with the Director of Nursing (DON), the DON stated Resident 56 was last seen by staff at 4:25 PM on January 25, 2026. The DON further stated Resident 56's sister came into the facility on January 25, 2026, to visit Resident 56 and when Resident 56's sister could not find the resident in his room, Resident 56's sister went to talk to Licensed Vocational Nurse 1 (LVN 1) at 5:15 PM to inquire about Resident 56's whereabouts. The DON stated a search for Resident 56 began and the resident could not be found anywhere in the facility. The DON stated Resident 56 was eventually found down the street in a parking lot next to a gas station at 6:03 PM. The DON stated cameras inside the facility were viewed by facility staff and it was identified that Resident 56 walked out the front door of the facility at 4:39 PM. The DON stated a staff member is usually assigned to be at the front desk (near the front door of the facility) until 8:00 PM, but at the time Resident 56 left unsupervised, there was nobody at the front desk because the individual who was scheduled to be at the front desk called off. During a review of Resident 56's Interdisciplinary Team (IDT) note dated January 26, 2026, the IDT note indicated, IDT met to discuss an event that occurred on 1/25/26 when resident was noted absent from facility. Upon the start of pm shift at 3 PM, charge nurse did usual rounds of the facility and noted resident in his room sleeping. By 4:25 PM last saw resident walking in the hallway. By 5:15 PM resident's sister was letting LVN know that he might be in the dining room because he was not in his room. Code for elopement announced. Search immediately conducted inside building (bedroom, bathrooms, closets, common areas) outside building. Staff drove around the vicinity. Police department notified at 5:48 PM. found resident off neighboring parking lot at 6:03 PM. Resident was brought back to facility grounds immediately. DON, administrator, and MD were notified. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Systems Approach to Safety. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. During a review of the facility's P&P titled, Wandering and Elopements, revised (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided assessment and monitoring for one of one resident (Resident 88) investigated for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys no longer function) when: a. There was no documented evidence staff performed assessment of Resident 88's dialysis access site every nursing shift (day, evening, and night shift) as ordered by the physician. b. There was no documented evidence to indicate staff performed a pre (before) and post (after) assessment of Resident 88's dialysis access site (the location where a dialysis machine is connected to a patient) for bruit (a low-pitched, rushing, or whooshing sound heard with a stethoscope over the site of a fistula) and thrill (a distinct, rhythmic buzzing or humming vibration felt upon palpation [touching] of a patient's vascular access) and bleeding. These failures had the potential for a delay in the staff identification and subsequent treatment of possible dialysis associated complications such as symptoms of infection, or severe bleeding for Resident 88. Findings: During a review of Resident 88's Face Sheet (contains medical and demographic information), the Face Sheet indicated Resident 88 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (kidney failure), dependence on renal dialysis (the state where an individual's kidneys have permanently failed and they require regular dialysis treatments to sustain life), anemia in chronic kidney disease (is a condition where damaged kidneys produce insufficient erythropoietin (EPO), a hormone necessary for producing red blood cells), and arteriovenous fistula (AV fistula - a dialysis access site formed by joining a vein and an artery in the arm). During a review of Resident 88's Minimum Data Set Assessment (MDS assessment - a comprehensive clinical assessment tool used in nursing homes to evaluate the physical, psychological, and psychosocial functioning of residents), dated January 27, 2026, the MDS assessment indicated in Section C (section for cognitive functioning), Resident 88 had a BIMS (Brief Interview for Mental Status - a 0-15 point assessment to screen for cognitive impairment) score of 14 (score of 13-15 means the resident is cognitively intact with normal thinking and memory). During a concurrent observation and interview on January 26, 2026, at 4:04 PM, in Resident 88's room, Resident 88 was lying in bed with his eyes closed. Resident 88 stated he had dialysis three times a week and his dialysis access site was on his right arm. Resident 88 stated the nurses from the facility did not always check his dialysis access site (AV fistula) when he returned from dialysis. a. During a review of Resident 88's care plan (an individualized plan for the medical care of a resident) titled, Potential for unavoidable bleeding on the AV shunt site and/or central line related to ESRD w/hemodialysis [with hemodialysis], dated January 23, 2026, the care plan indicated the following goal, Will reduce risk of occurrence of emergency bleeding through intervention daily until the next assessment. Interventions for the care plan included, document monitoring of dialysis site every shift and as needed for any evidence of changes in condition to include (but not limited to): bleeding, vital signs, access site patency (bruit/thrill), breathing pattern/breath sounds, level of consciousness, low b/p [blood pressure], diaphoresis [sweating], paleness. Notify physician of any changes. During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, resident may have dialysis with [name of dialysis clinic] Monday, Wednesday, Friday. During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, [DIALYSIS] Monitor for bleeding (document the following); 0 = absence 1 = presence, every shift. During a review of Resident 88's Medication Administration Record (MAR - a document used to record medications and treatments administered to the resident), dated January 2026, the MAR was blank for two of three shifts on January 24, 2026 (day shift and evening shift) for the task of monitor for bleeding. During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, [DIALYSIS] Monitor for swelling (document the following); 0 = absence 1 = presence, every shift. During a review of Resident 88's MAR, dated January 2026, the MAR was blank for two of (continued on next page)		

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 01/29/2026
NAME OF PROVIDER OR SUPPLIER Meadows Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three shifts on January 24, 2026 (day shift and evening shift) for the task of monitor.for swelling.During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, [DIALYSIS] Monitor.for pain (document the following); 0 = absence 1 = presence, every shiftDuring a review of Resident 88's MAR, dated January 2026, the MAR was blank for two of three shifts on January 24, 2026 (day shift and evening shift) for the task of monitor.for pain.During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, [DIALYSIS] Monitor shunt/graft site (document the following) BRUIT; (auscultate) [to listen with a stethoscope] 0 = absence of sound 1 = presence of sound, every shiftDuring a review of Resident 88's MAR, dated January 2026, the MAR was blank for two of three shifts on January 24, 2026 (day shift and evening shift) for the task of monitor shunt/graft site.Bruit.During a review of Resident 88's physician's orders, an order dated January 21, 2026, indicated, [DIALYSIS] Monitor shunt/graft site (document the following) THRILL; palpate [examine by touch] 0 = absence of vibration 1 = presence of vibration, every shiftDuring a review of Resident 88's MAR, dated January 2026, the MAR was blank for two of three shifts on January 24, 2026 (day shift and evening shift) for the task of monitor shunt/graft site.thrill.During a concurrent interview and record review on January 28, 2026, at 12:55 PM, with the Assistant Director of Nursing (ADON), the ADON stated staff were supposed to follow physician's orders and perform assessments of Resident 88's dialysis site every shift as ordered by the physician to ensure there were no complications like bleeding or a change in vital signs. Resident 88's MAR dated January 2026, was reviewed. The ADON acknowledged the five dialysis tasks for monitoring of bleeding, swelling, pain, bruit, and thrill were all blank for the day and evening shifts on January 24, 2026. The DON stated staff should be performing and documenting the assessments as ordered by the physician, but they did not.b. During a review of Resident 88's care plan titled, Potential for unavoidable bleeding on the A.V. shunt site and/or central line related to ESRD w/ hemodialysis. Dated January 20, 2026, the care plan indicated Resident 88 had an AV shunt site (for dialysis) on his right forearm. The care plan also indicated, Risks: 1. Adverse effect of dialysis 2. Compromise of dialysis access port.During a review of Resident 88's Dialysis Communication Record (document sent with resident to and from dialysis center for documentation of resident assessment prior to, during, and after dialysis treatments), dated January 23, 2026, the pre and post dialysis assessment conducted by the facility incorrectly indicated Resident 88 had a left upper arm shunt/graft (the resident had a right forearm shunt). Additionally, the Dialysis Communication Record, was also blank on the pre and post section of the form where it indicated whether bruit and thrill were present or absent. Furthermore, the question Bleeding at site: yes or no was left blank.During a concurrent interview and record review on January 28, 2026, at 12:49 PM, with the Assistant Director of Nursing (ADON), The ADON stated staff were supposed to document the assessment of the dialysis site and complete the pre and post dialysis assessment on the Dialysis Communication Record, on the days Resident 88 had dialysis. The ADON stated the importance of performing the pre and post dialysis assessment was to ensure there were no complications of the dialysis access site. Resident 88's Dialysis Communication Record, Dated January 23, 2026, was reviewed. The ADON acknowledged there was no documentation to indicate staff assessed bruit or thrill and bleeding at the dialysis site prior to or after the resident returned from dialysis.During a concurrent interview and record review on January 28, 2026, at 1:16 PM, with the Director of Nursing (DON), Resident 88's Dialysis Communication Record, dated January 23, 2026 was reviewed. The DON stated staff should be completing the form for the assessment thoroughly and stated there were blanks for the bruit, thrill, and bleeding at the site. The DON also stated staff documented that Resident 88 had his dialysis access site on his left upper arm but his active dialysis access site was on his right forearm.During a review of the facility's policy and procedure (P&P) titled, Care of Resident Receiving renal Dialysis, undated, the P&P indicated, Objective: To ensure that nursing staff are aware of special needs of residents receiving renal dialysis, and provide care accordingly.4. Nursing assessment identifies shunt area: a. check shunt area for bruit and thrill b. Obtain MD order for monitoring shunt area for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Meadows Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presence of bruit and thrill Q shift.9. Complete Dialysis Communication Record during dialysis days and send the form with the resident to be completed by the dialysis nurse. Completed Dialysis Communication Record will be sent back with resident and facility nurse will complete post dialysis. A. Complete pre-dialysis assessment: .iii. Access site (central line, shunt, graft site), iv. Document presence or absence of bruit and/or thrill, v. bleeding at site.B. Complete post-dialysis assessment on return from treatment.		