

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: 555350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Madison Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Laurel Ave Redlands, CA 92373	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to maintain infection control practices for four of two hundred and twenty-nine residents when: 1. Resident 40's nebulizer (a machine that turns liquid medicine into a mist to be inhaled) . An attached oxygen tubing (a plastic tube that delivers oxygen or misted medicine to the resident) has not been changed since September 1, 2025, (thirteen days past due). 2. For Resident 48, in an Enhanced Barrier Precaution (EBP - an infection control strategy used to reduce the spread of multi-drug-resistant organisms [MDROs] and prevent transmission to other residents and healthcare workers), Restorative Nursing Assistance (RNA 1) did not remove the gloves while providing care and reached out to her pocket and pulled out a walkie talkie to make a call.3. For Resident 154, the oxygen tubing (tubing connected to oxygen to assist breathing) was not labeled and dated as per facility's policy and procedure (P&P).4. For Resident 216, the nasal canula (tubing inserted into the nostrils used to deliver oxygen) was not changed for thirteen (13) days according to facility policy. These failures had the potential to place Resident 40, 48, 154 and 216 at risk for cross-contamination infection, (germs or bacteria from one dirty surface or item get spread to something clean, which can make people sick), infection (when germs enter the body and cause illness), and avoidable illness (sickness that could have been prevented if proper care or precautions were taken).1. During a review of review of Resident 40's admission Record (contains demographic and medical information), it indicated the resident was admitted to the facility on [DATE], with the diagnoses of shortness of breath (trouble breathing or feeling like it is hard to get enough air), wheezing (a whistling sound when breathing, cause by narrowed or blocked airways) and muscle weakness (when muscles are not strong, making it harder to move or do daily activities) During a concurrent observation and interview on September 14, 2025, at 10:44 AM, inside Resident's 40's room with Licensed Vocational Nurse/ Unit Manager (LVN UM 2), the LVN UM 2 inspected the nebulizer tubing, and it was dated September 1, 2025. The LVN UM 2 then inspected the nebulizer mask, and it was dated September 8, 2025 . The LVN UM 2 stated that the tubing and the mask are part of the same kit and should reflect the same date. The LVN UM 2 explained that the equipment was required to be changed weekly (every Sunday) for infection control purposes and verified that the conflicting dates were inaccurate. The LVN/UM further stated that staff probably wrote the wrong date on the tubing. During a review of Resident 40's physicians' orders, dated July 30, 2025, it indicated: Albuterol Sulfate Nebulization Solution (a liquid medicine that helps open the airways by relaxing the muscles in the lungs, used for wheezing and shortness of breath), 1.25 mg (MG- unit measured amount of the medicine)/ML (milliliters) inhaled orally via nebulizer every 4 (four) for shortness of breath related to wheezing). During a review of Resident 40's physicians' orders, dated September 14, 2025, it indicated, Changed out nebulizer mask, tubing, and set up bag weekly every night shift every Sun (Sunday). (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on September 17, 2025, at 10:32 AM with the infection Prevention Nurse (IP), the facility's policy and procedure (P&P) titled Respiratory Equipment Change Schedule, undated, was reviewed. The P&P indicted, Disposable equipment must be labeled with the date. Day: Sunday. Shift: Night shift. Supplies/equipment: Change O2 (oxygen) tubing, O2 adaptors, bubble humidifiers and connecting tubing. The IP stated that this policy was not followed by staff and further stated, the date should match. 2. During a review of Resident 48's clinical records, the admission Record, indicated, Patient 48 was admitted on [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic condition where body does resist or not produce enough insulin). gastro-esophageal reflux disease (GERD &ndash; a disease in which stomach acid irritates the food pipe lining), and elevated white blood cell count, unspecified (the body is producing more white blood cells to fight an infection or inflammation). During an observation and interview on September 17, 2025, at 10:25AM, with the RNA 1, in Resident 48's room, there was a sign outside the Resident 48's room and indicated, Enhanced Barrier Precautions. Providers and staff must also:. Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing. Bathing/showering. Transferring. Changing Linen. Providing Hygiene. RNA 1 was inside the room, providing care to Resident 48, reached into her pocket and pulled walkie talkie and made a call, RNA1 then put walkie-talkie back in her pocket. RNA 1 stated Sorry, I will go ahead and wash my hands, and I will wipe the Walkie-Talkie. RNA 1 further stated, she will never do it again. During an interview on September 17, 2025, at 10:40 AM, with LVN unit 3 managers (LVN UM) LVN UM, stated, she expects nursing staff to remove the gloves and use hand hygiene after any resident care. During an interview on September 17, 2025, at 10:58 AM, with DON, The DON stated, her expectation is for staff to follow infection control policies and procedures. During a concurrent interview and record review on September 17, 2025, at 12:02 PM, with the Infection Prevention Nurse (IP), the IP reviewed the facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene, revised October 2023. The P&P indicated, . 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene, 1.d after touching a resident. The IP stated her expectation of staff is to follow hand hygiene policy and procedure after providing care to a resident. IP further stated RNA 1 did not follow the hand hygiene policy. 3. During a review of Resident 154's admission Record (contains medical and demographic information), Resident 154 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (lung condition that causes ongoing damage to the airways and lungs, making it difficult to breathe), emphysema (chronic lung condition that causes shortness of breath), and shortness of breath (difficulty breathing). During further observation and interview on September 14, 2025, at 8:46 AM with a Registered Nurse Supervisor (RN 1) in resident 154's room, Resident 154 was lying in bed watching television, she was on four liters of oxygen. The oxygen tubing was unlabeled and undated. RN 1 stated oxygen tubing's are changed every Sunday. RN 1 further stated the oxygen tubing should have been labeled and dated. During a review of resident 154's physicians' orders, dated September 16, 2025, the physicians' (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	orders indicated, Oxygen- change oxygen tubing on Sunday NOC (night) shift of every week and date tubing. every night shift every Sunday for oxygen usage. During a concurrent interview and record review on September 17, 2025, at 10:23 AM, with the Infection Prevention Nurse (IP), the facility's policy and procedure (P&P) titled, Respiratory policies & procedures. Section: Infection control.Policy: Change of Disposable Equipment, revised December 7, 2018, was reviewed. The P&P indicated, Disposable equipment is for single resident use only and will be changed as regularly scheduled and on a PRN basis. Disposable equipment must be labeled with the resident's name and date. The IP stated the P&Ps were not followed and should have been followed for proper resident identification and for infection control purposes. 4.During a review of Resident 216's admission Record, it indicated Resident 216 was admitted to the facility with diagnoses that included, emphysema (chronic lung disease), severe persistent asthma (chronic condition where the lungs airways become inflamed and narrow) , hypertension (high blood pressure), and shortness of breath (difficulty breathing). During an observation on September 14, 2025, at 8:38 AM, in Resident 216's room, Resident 216 was lying in bed, wearing a nasal cannula that was attached to an oxygen concentrator (medical device that pulls in surrounding air, separates the nitrogen to concentrate the oxygen and delivers purified oxygen to a patient). The date on the nasal cannula tubing was September 1, 2025 (13 days have passed). During a concurrent interview and observation with Registered Nurse (RN 1) on September 14, 2025, at 9:47 AM, in Resident 216's room, RN 1 inspected Resident 216's nasal cannula and stated the date of the current nasal canula was September 1, 2025. The RN 1 stated the nasal canula tubing should have been changed every week as ordered, and this placed Resident 216 at increased risk for infection.		

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure the resident rights were respected for three (3) of 3 sampled residents (Resident 19, 53 and 54) when there was not contact information of state agencies posted in a manner that was accessible and understandable to residents and resident representatives on the first floor. This failure had the potential to result in Resident 19, 53 and 54 residents and resident representatives being unable to contact pertinent state agencies when needed to file a complaint. During an interview on September 15, 2025, at 8:28 AM, with Resident 19 his room, Resident 19 stated he was not aware of the location of state agency information, in case he needed to file a complaint. Resident 19 further indicated it would require staff assistance to locate the information since it had not been located on the first floor of the two-floor building. During a review of Resident 19's admission Record (contains demographic and medical information), it indicated, Resident 19 was admitted to the facility on [DATE], with diagnoses that included of end-stage renal disease, (ESRD- kidney failure), difficulty walking, absence of right leg below knee, and absence of left leg above knee. During a review of Resident 19's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (Cognitive [involving conscious intellectual activity] Patterns), dated September 1, 2025, the MDS Section C indicated, Resident 1 had a BIMS (Brief Interview for Mental Status- a tool used to screen how a resident is functioning cognitively) score of 15 (a BIMS score of 13-15 suggests resident cognitively intact). During an interview on September 15, 2025, at 8:48 AM, with Resident 53's representative outside of Resident 53 room, Resident 53's representative indicated not being ware of the location of the state agency information. During a review of Resident 53's admission Record, it indicated, Resident 53 was admitted to the facility on [DATE], with diagnoses that included, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control, dysphagia (difficulty swallowing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body). During a review of Resident 53's MDS Section C, dated July 8, 2025, the MDS Section C indicated, Resident 53 had a BIMS score of 2 (a BIMS score of 0-7 suggest severe cognitive impairment). During an interview on September 15, 2025, at 12:48 PM, with Resident 54 outside in the designated smoking area, Resident 54 stated he was not aware of the location of state agency information. Resident 54 was asked if it would be possible to locate the state agency information without staff involvement, Resident 54 responded it would not be. During a review of Resident 54's admission Record, it indicated, Resident 54 was admitted to the facility on [DATE], with diagnoses that included of Guillain-Barre syndrome (condition where the body's immune system mistakenly attacks its own nerves), type 2 diabetes mellitus, and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 54's MDS Section C dated July 16, 2025, the MDS Section C indicated, Resident 54 had a BIMS score of 15 (a BIMS score of 13-15 suggests resident cognitively intact). During an observation on September 15, 2025, at 2:00 PM, the first floor was observed to have the Long - Term Care Ombudsman Program posted information in the dinning room, the information for pertinent state agencies was not located on the first floor. During an interview on September 16, 2025, at 12:20 PM, with the Social Services Director (SSD). SSD indicated pertinent information for state agencies is located on the second floor away from the elevator. The SSD stated the information is not posted on the first floor or within the elevator. The SSD stated there were two hallways to go from the entrance to the elevator and the posting is not seen by residents and resident representative.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that two medication storage rooms were free of expired medical supplies. This failure had the potential to result in the use of expired medical supplies during resident care which may increased risk of infection (when germs like bacteria, virus or fungi enter the body, causing illness) to the vulnerable population. During a concurrent observation and interview on [DATE], at 10:11 AM, with Licensed Vocational Nurse (LVN 1), in the Medication Storage Room in Unit 400, there were six (6) Covid-19 Rapid Test with an expiration date of [DATE], and nine (9) Eswab Collection and transport systems (all-in-one device for collecting samples for bacterial testing) with expiration date of [DATE]. LVN 1 stated the supplies were past the expiration date and posed a risk for the residents. During a concurrent observation and interview on [DATE], at 11:58 AM, with the Registered Nurse (RN 4), in the Medication Storage Room in Unit 100. There were 171 safety pen needles (specialized insulin or medication device) with expiration date of [DATE]. The RN 4 stated these supplies were expired and posed an infection risk for the residents. During an interview on [DATE], at 2:30 PM, with Director of Nursing (DON), the DON was not able to provide a policy regarding the expired supplies. The DON stated there was no policy in place regarding medication supply or supply storage. When asked if expired supplies pose a risk to residents, the DON agreed.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of three sampled residents (Resident 10) when a Certified Nursing Assistant (CNA 1), stood while assisting Resident 10 with breakfast on September 15, 2025. This failure had the potential to negatively affect Resident 10's self-esteem and self-worth. During a review of Resident 10's admission Record (contains demographic and medical information), the admission Record indicated the Resident 10 was admitted to the facility on [DATE], with the diagnoses that included dysphagia (difficulty swallowing), hypertension (high blood pressure) and other abnormalities of gait and mobility (difficulty walking). During a review of Resident 10's physicians' orders, dated June 8, 2025, the physicians' orders indicated, Red Napkin Program (a program that notifies staff that residents need feeding assistance) with meals **1:1 (one-on-one) assist**. During a further review of Resident 10's diet orders, dated September 8, 2025, the diet orders indicated, Fortified (diet that includes foods that have been enriched with additional nutrients, such as vitamins, minerals, or protein) CCHO [Controlled or Constant Carbohydrate] NAS [No added salt] diet, Regular texture, Regular/Thin consistency, No spicy food, Lactose intolerant (inability to fully digest sugar in dairy products), **Red Napkin Program**. During an observation on September 15, 2025, at 8:15 AM in Resident 10's room, Resident 10 was sleeping in bed with a breakfast tray on his bedside table. Resident 10's meal ticket indicated resident requires feeding assistance. There was no documentation that indicated a preference for staff to stand. During further observation and interview on September 15, 2025, at 8:36 AM, in Resident 10's room, a Certified Nursing Assistant (CNA 1) was observed standing at the bedside while feeding Resident 10 for the duration of breakfast. When asked about the expectation when it comes to feeding residents, CNA 1 stated she was supposed to sit down while feeding to show respect. During a concurrent interview and record review on September 17, 2025, at 4:02 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Policy statement, undated, was reviewed. The P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . Policy interpretation and implementation . Residents requiring full assistance: . 2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, . The DON stated staff are expected to sit while feeding residents unless the resident has a preference.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident care plans (personalized document that outlines healthcare support needs of an individual) for antibiotics (medicine used to treat infections) was developed for two of three sampled residents (Resident 4 and 15) . This failure had the potential to place two residents at risk for lack of planning for adverse side effects to antibiotics and unmet care needs for Residents 4 and 15.1. During a review of Resident 4's admission Record (contains demographic and medical information), it indicated Resident 4 was admitted to the facility on [DATE], with the diagnoses of cerebral infarction (blood flow to the brain is interrupted leading to damage), candidal sepsis (fungal infection in bloodstream), and shortness of breath. During an observation on September 14, 2025, at 11:44 AM, in Resident 4's room, Resident 4 was lying in bed, asleep. Resident 4 had an intravenous site (location on body where a catheter is inserted into a vein) on her right wrist. During a review of Resident 4 physician's order dated September 13, 2025, it indicated Cephalexin (type of antibiotic) Oral Suspension (liquid to give my mouth) . 250mg (milligram- unit of measurement) /5ml (milliliter- unit of measurement) . Give 10 ml via G-tube (gastrostomy tube- tube inserted into stomach to give food or medications) every 12 hours for UTI (urinary tract infection - urine infection) for 5 Days. During a concurrent interview and record review on September 17, 2025, at 12:39 PM, with the Registered Nurse Unit Manager (RN UM), Resident 4's care plan was reviewed. RN UM stated she could not see a care plan for the Cephalexin antibiotic for UTI. RN UM further stated there should have been a care plan because the care plan guides the plan of care.2. During a review of Resident 15's admission Record, it indicated Resident 15 was admitted to the facility on [DATE], with the diagnoses of hemiplegia and hemiparesis following cerebral infarction (weakness or loss of movement on one side of body), elevated white blood cell count (high number of cells that fight infections), and pneumonia (inflammation of the lungs caused by infection). During an observation on September 14, 2025, at 2:58 PM, in Resident 15's room, Resident 15 was lying in bed, awake and staring at the wall. Resident 15 had an intravenous site on his right wrist. During a review of Resident 15's Order Summary Report, dated September 16, 2025, it indicated, Resident 15 had a physician order for Cefoxitin (antibiotic used to treat infections) sodium intravenous (through a vein) solution. 1 GM (gram- unit of measurement) . use 1 gram intravenously every 8 hours for UTI (urinary tract infection - urine infection) for 7 days. During a concurrent interview and record review on September 17, 2025, at 12:45 PM, with the RN UM, Resident 15's care plan was reviewed. RN UM stated she could not see a care plan for the cefoxitin antibiotic for UTI. RN UM further stated there should have been a care plan for Resident 15's antibiotic. During a concurrent interview and record review on September 17, 2025, at 2:32 PM, with the DON, the facility's undated policy and procedure (P&P) titled, Care Planning - Interdisciplinary Team [IDT - a group of professionals from various disciplines who work together to develop a plan of care], undated, was reviewed. The P&P indicated The interdisciplinary team is responsible for the development of resident care plans. 2. Comprehensive, person-centered care plans are based on resident assessment and developed by an interdisciplinary team (IDT) . 3. The IDT includes but is not limited to: . b. a registered nurse with responsibility for the resident; . The DON stated that the care plan is a living document to guide care. The DON further stated the P&P was not followed.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident food preferences were provided for one of three sampled residents (Resident 37) reviewed for nutrition, when Resident 37 did not receive 8 ounces (oz- unit of measurement) of whole milk for lunch as indicated on Resident 37's meal ticket (a piece of paper indicating allergies, preferences, and likes/dislikes), on September 14, 2025. This failure had the potential to cause nutritional decline and unmet care needs for Resident 37. During a review of Resident 37's admission Record (contains demographic and medical information), it indicated Resident 37 was admitted to the facility on [DATE], with diagnoses that included hypertensive heart disease with heart failure (high blood pressure damages the heart over time), unspecified dementia (group of conditions that cause a decline in memory, problem-solving and language), and dysphagia (difficulty swallowing). During a review of Resident 37's Diet Order, dated September 5, 2025, it indicated fortified diet (added calories), minced and moist (soft, finely cut and well-moistened food, no larger than 4 millimeters) texture, regular/thin consistency. During a concurrent observation and interview on September 14, 2025, at 12:28 PM, in Resident 37's room, Resident 37 was sitting up in bed, lunch was placed on the bedside table over her bed. Resident 37's lunch contained minced meat, vegetables, rice and mashed potatoes, with 4oz of whole milk and 8oz of water. Resident 37 stated her meal tasted very good. Resident 37's meal ticket indicated . 8 fl (fluid) oz milk whole. During a concurrent observation and interview and record review, on September 14, 2025, at 1:04 PM, with Licensed Vocational Nurse Unit Manager (LVN UM), in Resident 37's room, Resident 37's meal and meal ticket were reviewed. LVN UM stated Resident 37 should have been served 8oz of whole milk instead of 4oz, as specified in the meal ticket. LVN UM further stated her expectation was for staff to verify Resident 37 received the correct amount of milk. During a concurrent interview and record review, on September 17, 2025, at 2:30 PM, with the Director of Nursing (DON), the facility's undated policy and procedure (P&P) titled, Food and Nutrition Services, undated, was reviewed. The P&P indicated Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 5. The food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. The DON stated Resident 37's tray was missed, and P&P was not followed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medications were administered without errors, for one of 11 residents (Resident 247) observed for medication pass, when LVN 3 was to administer Gabapentin (an anticonvulsant medication used to treat certain types of seizures and specific kinds of nerve pain) and Valproic acid (a medication used to treat seizure disorders, the manic phase of bipolar disorder, and to prevent migraine headaches), according to the physician's orders This failure had the potential for Resident 247 medications not to be administered in the correct prescribed route by the physician and had the potential to increase Resident 247's risk for harm. During a review of Resident 247's clinical record, the admission Record (contains demographic and medical information), indicated Resident 247 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing) and type 2 diabetes mellitus (a chronic condition where body does resist or not produce enough insulin). During a review of Resident 247 's physician order, dated September 3, 2025, it indicated Resident 247 had an order for Gabapentin oral tablet 800 MG (MG - milligrams, unit of measurement) give one tablet by Percutaneous Endoscopic Gastrostomy (PEG tubes - a feeding tube that allows a person to receive nutrition through the stomach), every eight hours for neuropathy (damage or dysfunction of the peripheral nerves, that causes symptoms such as pain, numbness, tingling, and muscle weakness). During a review of Resident 247 's physician order, dated September 15, 2025, it indicated Resident 247 had an order for Valproic acid oral solution 250 mg (milligrams) /5 mL (mL - milliliter unit of measurement) give 20 mL via PEG-tube every eight hours for seizure disorder. During a medication administration observation on September 16, 2025, at 6:21 AM, with Licensed Vocational Nurse (LVN 3), in Resident 247's room. LVN 3 prepared Resident 247's Gabapentin tablet 800 mg and Valproic acid oral solution and proceeded to administered to Resident 247 by mouth. The surveyor intervened and stopped the oral administration. During an interview on September 16, 2025, at 6:42 AM with LVN 3, LVN 3 stated, Resident 247 preferred to have his medication by mouth. LVN 3 further stated, she had administered Resident 247's medications by mouth for the past three days. The LVN 3 further stated, she thought they have changed the order to oral route. The LVN 3 was not able to provide documented evidence of Resident 247's physician orders for to administer Gabapentin and Valproic acid via oral administration. During a concurrent interview and record review, on September 16, 2025, at 8:45 AM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled, Administering Medication, revised April 2019. The P&P indicated, . 6. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.The DON stated, medication administered by not following the order route, it is considered an error. The DON further stated, LVN 3 should have followed the order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Madison Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Laurel Ave Redlands, CA 92373	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. There were two medication errors observed out of a total of 27 opportunities for errors, affecting one of 11 observed residents (Residents 247), resulting in an overall medication error rate of 7.41 percent when Resident 247 had an order to receive all medication through Percutaneous Endoscopic Gastrostomy (PEG - a feeding tube that allows a person to receive nutrition through the stomach) and it was to be administered by mouth by a Licensed Vocational Nurse (LVN 3). This failure had the potential for Resident 247 medications not to be administered in the correct prescribed route by the physician and had the potential to increase the Resident 247's risk of harm. During a review of Resident 247's clinical record, the admission Record (contains demographic and medical information), indicated Resident 247 was admitted to the facility on [DATE], with diagnoses which included dysphagia, unspecified difficulty in swallowing) and type 2 diabetes mellitus (a chronic condition where body does resist or not produce enough insulin). During a review of Resident 247 's physician order, dated September 3, 2025, it indicated Resident 247 had an order for gabapentin (is an anticonvulsant medication used to treat certain types of seizures and specific kinds of nerve pain) oral tablet 800 MG (MG - milligrams, unit of measurement) give one tablet by Percutaneous Endoscopic Gastrostomy (PEG - a feeding tube that allows a person to receive nutrition through the stomach), every eight hours for neuropathy (damage or dysfunction of the nerves, especially the peripheral nerves, that causes symptoms such as pain, numbness, tingling, and muscle weakness). During a review of Resident 247 's physician order, dated September 15, 2025, it indicated Resident 247 had an order for Valproic acid (a medication to treat seizures) oral solution 250 mg/5 mL (mL- milliliter, unit of measurement) give 20 mL via PEG-tube every eight hours for seizures disorder. During a medication administration observation on September 16, 2025, at 6:21 AM, with Licensed Vocational Nurse (LVN 3), in Resident 247's room. LVN 3 prepared Resident 247's Gabapentin tablet 800 mg and Valproic acid oral solution 250 mg/5 mL and proceeded to administered to Resident 247 by mouth. The surveyor intervened and stopped the oral administration. During an interview on September 16, 2025, at 6:42 AM with LVN 3, LVN 3 stated, Resident 247 preferred to have his medication by mouth. LVN 3 further stated, she had administered Resident 247's medications by mouth for the past three days. The LVN 3 further stated, she thought they have changed the order to oral route. The LVN 3 could not provide documented evidence of Resident 247's physician orders for to administer Gabapentin and Valproic acid via oral administration. During a concurrent interview and record review, on September 16, 2025, at 8:45 AM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled, Administering Medication, revised April 2019. The P&P indicated, . 6. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The DON stated that medication administered by not following the order route, it is considered an error. The DON further stated, LVN 3 should have followed the order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Madison Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Laurel Ave Redlands, CA 92373	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment for one of 10 residents (Resident 54) reviewed for smoking, when the rain gutter (a long, hollow channel, often made of metal or plastic, attached to the edge of a roof to collect rainwater and direct it away from the buildings foundation) above the door of the smoking area was not maintained and caused a constant leak to the walkway. This failure had the potential to expose Resident 54 to unsafe walkway conditions when entering the smoking area, due to structural damages and increased the risk for falls. During a review of Resident 54's admission Record (contains demographic and medical information), it indicated, Resident 54 was initially admitted to the facility on [DATE], with the medical diagnosis of Guillain-Barre syndrome (autoimmune condition where the body's immune system mistakenly attacks its own peripheral nerves), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a concurrent observation and interview on September 15, 2025, at 12:48 PM in the smoking area with Resident 54, Resident 54 stated that there was a constant drip of water located directly next to the door of the smoking area. There were multiple saturated towels and a yellow caution sign was noted next to the towels. During a concurrent observation and interview on September 16, 2025, at 9:03 AM, in the smoking area with the Director of Maintenance (DOM), the DOM stated the there had been no work order issued for the drip. DOM stated the drip is from a gutter connected to the station three bridge. DOM further indicated there was an unknown black substance on the gutter. DOM indicated the drip is in the walk way of residents. The DOM stated there is no maintenance policy in place.		