

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Meadowood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3805 Dexter Lane Clearlake, CA 95422	

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 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide one of five sampled residents (Resident 1) with nursing care in a manner that maintained his dignity and respect, when Registered Nurse 1 (RN 1):1. Did not cease performing a rectal (of, relating to, or situated near the rectum, which is the final section of the large intestine) treatment/procedure after Resident 1 complained of pain and asked RN 1 to stop.2. Did not ensure privacy during care/treatment which required Resident 1 to be partially unclothed from the waist down.3. Did not provide explanation of care/treatment to Resident 1 prior to performing an invasive (involving the introduction of instruments or other objects into the body or body cavities) rectal medication insertion. (See F552 for additional information).These failures caused Resident 1 to experience pain, anxiety, and to feel violated and embarrassed. These failures also caused Resident 1 to experience serious psychosocial trauma (distressing thoughts and symptoms that last for more than two weeks after a traumatic event). Record review of the facility Face Sheet (facility demographic) indicated Resident 1 was originally admitted to the facility on [DATE] with medical diagnoses which included post laminectomy syndrome (a condition, where part of the bone (lamina) covering the spinal cord is removed and causes persistent or recurring pain, tingling and numbness in the buttocks and legs) and constipation (a condition characterized by infrequent or difficult bowel movements).A review of Resident 1's Clinical Physician Orders, last reviewed on 8/27/25, indicated Resident 1 was prescribed, Dulcolax Rectal Suppository (a small, solid medication plug designed to be inserted into the rectum (the final section of the large intestine, connecting the colon to the anus, where stool is stored before it is expelled from the body). It melts and releases its medication into the bloodstream through the rectal wall to relieve constipation), 10 milligrams (a unit of measure), insert suppository rectally every 24 hours as needed for constipation.During a review of Resident 1's Minimum Data Set - C (MDS- a resident assessment tool), dated 9/12/25, the MDS indicated Resident1's cognitive (the ability to think and process information) skills for daily decision making were intact.During a review of Resident 1's MDS - D (a mood assessment), dated 9/14/25, it indicated Resident 1 was mildly depressed, based on a score of six (6) out of 27 possible points. Assessment questions indicated Resident 1 had no sleep, energy, or loss of interest problems. During a review of Resident 1's MDS - I (active diagnoses), dated 9/14/25, it indicated Resident 1 was not diagnosed with PTSD (Post-Traumatic Stress Disorder-a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal assault), or any other psychiatric/mood disorder other than depression.Record review of a nursing note dated 9/15/25 at 10:31 p.m., indicated, RESIDENT FELT VIOLATED AFTER RN ADMINITERED (sic) RECTAL SUPPOSITORY.During an interview on 9/17/25 at 9:30 a.m., Resident 1 stated that on 9/15/25 at approximately 10:30 p.m., Registered Nurse 1 (RN 1) inserted a suppository into his rectum at his request. According to Resident 1, Certified Nursing Assistant 1 (CNA 1) was assisting by helping turn Resident 1 to his side to facilitate the insertion. Resident 1 stated RN 1 inserted the suppository into his rectum and swirled her finger around one way inside his rectum, then the other way, continuing for a total of about four (4) minutes. Resident 1 stated he complained of pain and requested that RN 1 stop about three (3) minutes into the procedure, however RN 1 did not stop. Resident 1 stated that RN 1 told him, I need to do this so it will dissolve. Resident 1 stated he was embarrassed by this, and felt he was raped. Resident 1 also stated that while this incident was occurring, staff did not pull the privacy curtain around his bed, and the door to the hallway was open.During a phone interview on 9/17/25 at 11:20 a.m., CNA 1 confirmed being present during the above incident with Resident 1 and RN 1. CNA 1 stated she assisted RN 1 by turning Resident 1 on his side, so RN 1 could insert the suppository. CNA 1 stated she estimated RN 1 took five (5) to ten (10) minutes to insert the suppository, and she felt this timing to be extensive since other nurses she witnessed giving suppositories could accomplish the procedure in less than a minute. RN 1 began by inserting the suppository into Resident 1's rectum, and, after about three (3) minutes, CNA 1 stated Certified Nursing Assistant 2 (CNA 2) came back into Resident 1's bedroom and gave CNA 1 a look which she perceived as, this isn't right. CNA 1 stated Resident 1 then complained it was taking too long and RN 1 replied, I have to move my finger around so it will activate. CNA 1 stated a few minutes later, RN 1 removed her finger from Resident 1's rectum and left the room. CNA 1 stated Resident 1 looked visibly upset after the procedure, so she stayed to comfort and talk to Resident 1, while Certified Nursing Assistant 2 (CNA 2) reported the incident to the Charge Nurse (VN 1) on duty. During an interview on 9/17/25 at 12:15 p.m. with the Assistant Director of</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse within two hours to the DEPARTMENT for one of five (5) sampled residents (Resident 1). This finding had the potential to result in inability for the DEPARTMENT to investigate and advocate for Resident 1's rights, and possible continuous abuse to Resident 1 and other residents of the facility. Record review of the facility Face Sheet (facility demographic) indicated Resident 1 was originally admitted to the facility on [DATE] with medical diagnoses which included post laminectomy syndrome (a condition, where part of the bone (lamina) covering the spinal cord is removed and causes persistent or recurring pain, tingling and numbness in the buttocks and legs) and constipation (a condition characterized by infrequent or difficult bowel movements). Record review of a form titled, SOC-341 (a specific form used in California for Mandated Reporters to document and report suspected Dependent Adult or Elder Abuse), the facility sent and was received at DEPARTMENT on 9/16/25 at 10:06 a.m., indicated, Resident [Resident 1] requested a suppository and when RN [Registered Nurse 1] went to give it he states that, she swirled the suppository around inside his rectum and it took too long. When he questioned her she stated I have to activate it, so it works. He felt violated and almost had an erection of how long the nurse took. During an interview on 9/17/25 at 9:30 a.m., Resident 1 stated the incident occurred on 9/15/25 at approximately 10:30 p.m. Record review of a nursing note dated 9/15/25 at 10:31 p.m., indicated, RESIDENT [Resident 1] FELT VIOLATED AFTER RN (Registered Nurse 1) ADMINITERED (sic) RECTAL SUPPOSITORY. During a concurrent interview and record review on 9/17/25 at 9:58 a.m. with the Assistant Director of Nursing (ADON), a fax confirmation log showing transmissions from the facility fax was requested. The log was reviewed and showed no faxes sent (or attempted) from the facility to the DEPARTMENT on 9/15/25. During a phone interview on 9/18/25 at 11:15 a.m., the Administrator (ADM) stated she was notified on the abuse allegation made by Resident 1 at 9/15/25 at 10:58 p.m. by Charge Nurse (LVN 1), who explained she sent a fax to the DEPARTMENT within two hours of the abuse allegation (on 9/15/25) for notification purposes. The ADM stated she was unable to find evidence of this fax, therefore, she called the DEPARTMENT on the morning of 9/16/25 to confirm the DEPARTMENT received Resident 1's abuse allegation dated 9/15/25. The ADM stated the DEPARTMENT told her they did not receive notification of the abuse incident on 9/15/25, so the ADM faxed the SOC-341 to the DEPARTMENT on 9/16/25 at approximately 9:00 a.m. Record review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 2022, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) .Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p>		

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) received care and services in accordance with professional standards of practice when: 1. Registered Nurse 1 (RN 1) performed a digital stool dis-impaction (a procedure to remove hardened, impacted stool from the rectum using a lubricated, gloved finger, which is inserted into the rectum to break up and extract the stool) procedure for Resident 1 without a physician's order. 2. Facility did not provide licensed nursing staff (RN 1, Registered Nurse 2, Registered Nurse 3) sufficient education and training regarding rectal suppository (a small, solid medication plug designed to be inserted into the rectum. It melts and releases its medication into the bloodstream through the rectal wall) insertion and digital rectal stool dis-impaction (see F726 for additional information). This failure resulted in Resident 1 experiencing discomfort, confusion and anxiety during and after the procedure, and the potential for all facility residents to receive substandard rectal medication administration and treatment. Record review of the facility Face Sheet (facility demographic) indicated Resident 1 was originally admitted to the facility on [DATE] with medical diagnoses which included post laminectomy syndrome (a condition, where part of the bone (lamina) covering the spinal cord is removed and causes persistent or recurring pain, tingling and numbness in the buttocks and legs) and constipation (a condition characterized by infrequent or difficult bowel movements). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 9/12/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were intact. A review of Resident 1's Clinical Physician Orders, last reviewed on 8/27/25, indicated Resident 1 was prescribed, Dulcolax Rectal Suppository (a small, solid medication plug designed to be inserted into the rectum (the final section of the large intestine, connecting the colon to the anus, where stool is stored before it is expelled from the body). It melts and releases its medication into the bloodstream through the rectal wall to relieve constipation), 10 milligrams (a unit of measure), insert suppository rectally every 24 hours as needed for constipation. Record review of a nursing note dated 9/15/25 at 10:31 p.m., indicated, RESIDENT FELT VIOLATED AFTER RN ADMINISTERED (sic) RECTAL SUPPOSITORY. During an interview on 9/17/25 at 9:30 a.m., Resident 1 stated on 9/15/25 at approximately 10:30 p.m., Registered Nurse 1 (RN 1) inserted a suppository into his rectum at his request. According to Resident 1, Certified Nursing Assistant 1 (CNA 1) was assisting by helping turn Resident 1 to his side to facilitate the insertion. Resident 1 stated RN 1 inserted the suppository into his rectum and swirled her finger around one way inside his rectum, then the other way, continuing for a total of about four (4) minutes. Resident 1 stated he complained of pain and requested that RN 1 stop about (3) three minutes into the procedure, however RN 1 did not stop. Resident 1 stated that RN 1 told him, I need to do this so it will dissolve. Resident 1 stated he was embarrassed by this, and felt he was raped. During a phone interview on 9/17/25 at 11:20 a.m., CNA 1 confirmed being present during the above incident with Resident 1 and RN 1. CNA 1 stated she assisted RN 1 by turning Resident 1 on his side, so RN 1 could insert the suppository. CNA 1 stated she estimated RN 1 took five (5) to ten (10) minutes to insert the suppository, and she felt this timing to be extensive since other nurses she witnessed giving suppositories could accomplish the procedure in less than a minute. CNA 1 stated a few minutes into the procedure, Resident 1 complained it was taking too long and RN 1 replied, I have to move my finger around so it will activate. According to CNA 1, a few minutes later, RN 1 removed her finger from Resident 1's rectum and left the room. CNA 1 stated Resident 1 looked visibly upset after the procedure and she stayed to comfort him and talk, while Certified Nursing Assistant 2 (CNA 2) reported the incident to the charge nurse on duty. During an interview on 9/17/25 at 12:15 p.m. with the Assistant Director of Nursing (ADON), she stated the process for inserting a suppository involved rolling the resident to his side, inserting the lubricated suppository with a gloved hand and pulling the hand back out immediately after administration. The ADON stated if resistance was met during the procedure due to a collection of stool in the bowel, the nurse should try to push it slightly but if the resident was to complain of pain, the nurse was required to stop right away. During a phone interview on 9/18/25 at 1:40 p.m., RN 1 stated on the evening of 9/15/25, she inserted the suppository into Resident 1's rectum, she felt something hard that she believed to be stool. RN 1 stated she then moved her finger around inside Resident 1 for about (6) six seconds, to break up the stool so she could insert the suppository, and it could dissolve. RN 1 stated stool came out of Resident 1, along with a lot of gas. When asked to describe what dis-impaction was, RN 1 stated moving stool around so it can pass and</p>		