

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 12/04/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was protected from neglect when physician notification regarding her change of condition (COC, a significant shift in someone's physical, mental or functional state, requiring attention) was delayed. This failure resulted in Resident 1 to experience delays in care and required hospitalization for an unmanaged fever, altered level of consciousness (sudden changes in condition, awareness or consciousness (your subjective awareness to yourself and the world)) and sepsis (a life-threatening blood infection). Cross reference F761.A review of Resident 1's admission record indicated she was admitted to the facility in May 2025 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness), and peripheral venous insufficiency (a condition where the valves in the leg veins are damaged causing blood to pool in the lower legs instead of flowing back to the heart). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 9/26/25, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 14, which indicated she had minimal cognitive impairment (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 1's progress notes, type, Respiratory Therapy Note, dated 11/18/25 at 10:49 a.m., indicated, Resident had a resting hear [heart] rate [the number of times the heart beats each minute while the person is awake, calm, and not moving] of 117 [117 beats per minute (bpm); normal heart rate is between 60 to 100 bpm] and was constantly shaking and complaining of being cold nurse was notified.A review of Resident 1's progress notes, type, Nursing Notes, dated 10/18/25 at 1:40 p.m., Licensed Nurse 1 (LN 1) indicated, Resident has elevated temperature at 100.2 F [Fahrenheit, a temperature scale; normal temperature is 98.6 F] this shift. Tylenol [acetaminophen, a medication to treat mild to moderate pain] PRN [as needed] given.A review of Resident 1's progress notes, type, Respiratory Therapy Note, dated 11/18/25 at 3:42 p.m., indicated, Resident has an spo2 [peripheral (referring to outer areas like hands/feet) oxygen saturation, measures the percentage of oxygen-carrying hemoglobin in your blood; normal range is between 95% to 100%] of 87% on room air. Resident placed on 2L [liters, a unit of measurement; volume of oxygen] of oxygen spo2 on oxygen 92%. Resident shaking with fever of 103.6 [F] nurse notified.A review of Resident 1's SBAR (Situation, Background, Assessment and Recommendation, a communication technique used in healthcare to facilitate clear and concise information) form dated 10/18/25 at 5:05 p.m., indicated, The change in condition, symptoms, or signs observed and evaluated is/are: fever.Resident temperature was 103 F 30 mins [minutes] ago, cooling measures started, fluids pushed, then rechecked. Fever now 104.6 F.This started on: 10/18/25. Since this started it has gotten: Worse [check marked].Mental Status Evaluation: Altered level of consciousness.Summarize your observations and evaluation: Resident noted to be febrile [having or showing symptoms of a fever], shaking, and not responding normally to baseline. Charge nurse called MD [medical doctor] and received order to send out to ER [emergency room] for further eval [evaluation] and treatment.Primary Care Clinician [MD] notified: 10/18/25 at 5:05 p.m.A review of Resident 1's undated document, titled, SNF (skilled nursing facility)/NF (nursing facility) to Hospital Transfer Form, indicated Resident 1's date of transfer was 10/18/25 at 5:04 p.m.A review of [name of hospital] document titled, History and Physical Examination, dated 11/18/25 at 11 p.m., indicated, 74 y/o [year old] female in via EMS [Emergency Medical Service] from [name of skilled nursing facility] with fever, altered mental status. admission status: Fever, Sepsis. During a phone interview on 11/13/25 at 1:17 p.m. with LN 2, she stated she could not recall the date Resident 1 had a COC; however, she recalled Resident 1 with a golf ball sized spot of redness to her upper left leg the night before. LN 2 further stated the following day she was informed in hand-off (a report given between off and on coming staff regarding resident updates) from the AM (morning) staff that the redness had worsened and was down to her [Resident 1] knee. LN 2 confirmed Resident 1 had a fever that developed in the morning. LN 2 stated, It would have been appropriate to send her out [to the hospital] earlier. LN 2 confirmed the expectation for reporting a COC was to notify the MD as soon as the COC was assessed. LN 2 stated, If a fever is left untreated you can have a seizure and become unresponsive.During an interview on 11/13/25 at 2:53 p.m. with Resident 1, she stated in mid-October she had a day where she was really out of it and was sent to the hospital.During a phone interview on 11/14/25 at 12 p.m. with Certified Nurse Assistant 1 (CNA 1), she confirmed she assisted Resident 1 the day she developed the fever. CNA 1 verified Resident 1's COC happened in October 2025 during AM shift. CNA 1</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to ensure professional standards of nursing practice were followed for a census of 89 residents when:1: One resident's (Resident 1) medication was left by her bedside unattended by staff without a physician order for self-administration of medications,2: An undisclosed number of residents' medications were pre-prepared (a type of workaround, described as a delay between preparation and administration of a medication or the preparation of multiple medications for different residents) prior to administration, and;3: The Director of Nursing (DON) allowed the administration of pre-prepared medications to residents; fully aware they were unlabeled and had been pre-prepared. These failures increased the facility's potential for medication errors and for residents to experience a delay in care and treatment.1. A review of Resident 1's admission record (Facility demographic) indicated she was admitted to the facility in May, 2025, with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness), and peripheral venous insufficiency (a condition where the valves in the leg veins are damaged causing blood to pool in the lower legs instead of flowing back to the heart). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 9/26/25, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 14, which indicated she had minimal cognitive impairment (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 1's order summary report, order date range 10/1/25-10/31/25, indicated two tablets of acetaminophen (a medication used to relieve mild to chronic pain and reduce fever)325 mg(milligrams) per tab, was to be administered to Resident 1 by mouth every four hours as needed for pain ranging from one to ten (a pain scale where zero signifies no pain and ten is the worst pain experienced during a person's lifetime). This summary report did not indicate medications could be left by Resident 1's bedside for self-administration of medications. A review of Resident 1's care plan did not indicate Resident 1 was capable of self-administration of medications. A review of Resident 1's Medication Administration Record (MAR) dated October, 2025, indicated, acetaminophen tablet 325 mg give 2 tablets by mouth every 4 hours as needed for pain [1-10 pain scale].start date 8/1/25, was administered on 10/18/25 at 1:26 p.m. by Licensed Nurse 1 (LN 1). A review of Resident 1's progress notes, type, Nursing Notes, dated 10/18/25 at 1:40 p.m., documented by LN 1 indicated, Resident has elevated temperature at 100.2 F [Fahrenheit, a temperature scale; normal temperature is 98.6 F] this shift. Tylenol [acetaminophen] PRN [as needed] given. A review of Resident 1's SBAR (Situation, Background, Assessment and Recommendation, a communication technique used in healthcare to facilitate clear and concise information) form dated 10/18/25 at 5:05 p.m., indicated, The change in condition, symptoms, or signs observed and evaluated is/are: fever. Resident temperature was 103 F 30 mins [minutes] ago, cooling measures started, fluids pushed, then rechecked. Fever now 104. 6 F.A review of [name of hospital] document titled, History and Physical Examination, dated 11/18/25 at 11:00 p.m., indicated, 74 y/o [year old] female in via EMS [Emergency Medical Service] from [name of skilled nursing facility] with fever, altered mental status [sudden changes in condition, awareness or consciousness].admission status: Fever, Sepsis [the body's extreme, life-threatening response to an infection].During an interview on 12/04/25 at 12 p.m., with the Director of Staff Development (DSD), she stated she assessed Resident 1 on the evening of 10/18/25 (prior to being transferred to a hospital) and Resident 1 was found slumped (having the head low and shoulders forward) over and shivering. The DSD stated she observed Resident 1's Tylenol in a cup on Resident 1's bedside table. The DSD confirmed Resident 1 did not take the Tylenol that was prepared for her to treat her fever. The DSD stated Resident 1's temperature was approximately 104 F from a previous reading of approximately 103 F (which indicated an increase in fever).During an interview on 12/04/25 at 12:20 p.m. the DON stated medications could not be left by residents' bedsides. The DON stated, They [Licensed Staff] are expected to stay there with them [residents] to take their medications. They [Licensed Staff] are not allowed to leave them [residents] because anybody could take their medications. The DON further stated residents could choke or drop their medications and not actually take them [when left unattended by their bedside]. The DON confirmed that Licensed Staff were expected to ensure residents were taking the medications they were handed by Licensed Staff. During a review of the facility policy and procedure (P&P) titled, Self-Administration of Medications, dated 2021, the P&P indicated, If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan</p>		