STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555490	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowood Nursing Center	3805 Dexter Lane Clearlake, CA 95422

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interviews and record reviews, the facility failed to ensure one out of two sampled residents (Resident 1) right to self-determination was honored when Resident 1 was not discharged from the facility per his request on 1/28/26.This failure left Resident 1 at risk for feeling upset and frustrated.Findings: Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated an admission date to the facility in 11/2025 with diagnoses of Essential Hypertension (HTN, high blood pressure and Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).A review of Resident 1's physician's Order Summary (POS, a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive) indicated that on 11/11/25, the physician deemed Resident is capable of understanding rights, responsibilities and informed consent.A review of Resident 1's Alert Note (documentation method used to instantly notify staff of critical, time-sensitive information regarding a resident's status), dated 1/29/26 written at 12:46 a.m., indicated, At aproximatley [sic] [8:30 p.m. on 1/28/26].requesting an explanation as to why [Resident 1] could not leave the facility at this time, this nurse. explained that per facility protocol and due to safety concerns [Resident 1] was not cleared to leave at this time and that a discharge care meeting could be arranged during normal business hours.This nurse informed [Resident 1's visitor] that [Resident 1] could not leave at the time and that leaving would be unsafe and against medical advice.During an interview and concurrent record review with the Social Services Director (SSD) on 2/20/26 at 2:31 p.m., Resident 1's physician orders were reviewed. The SSD verified that based on physician order, Resident 1 was responsible for himself, understanding his rights and responsibilities. The SSD stated Resident 1 had told the SSD he wanted to discharge from the facility on the evening of 1/28/26. The SSD stated, despite being responsible for himself, Resident 1 was not allowed by staff to discharge.During an interview on 2/20/26 at 3:11 p.m., the Assistant Director of Nursing (ADON) verified Resident 1 was responsible for himself and the physician had deemed him capable of making decisions for himself. The ADON stated when Resident 1 wanted to discharge on [DATE], staff should have offered Resident 1 to sign a release of responsibility form and he should have been allowed to discharge. ADON confirmed staff did not offer Resident 1 to sign a release of responsibility form. The ADON stated not allowing Resident 1 to discharge from the facility could be seen as not honoring Resident 1's rights. The ADON added, not allowing Resident 1 to discharge, despite his wish to do so, could result in Resident 1 experiencing anger, frustration and resentment.During a telephone interview on 2/20/26 at 4:18 p.m., Resident 1 stated in regards to wanting to discharge on [DATE], yes, I wanted to go home at that time but was not allowed to do so. Resident 1 stated that when he was not allowed to go home he was really upset and frustrated.During a telephone interview on 2/20/26 at 4:53 p.m., LN B stated on the evening of 1/28/26, Resident 1 stated he wanted to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge from the facility. LN B stated, I told [Resident 1] it was late, can't figure anything out at night, and there were no administrative staff at night. LN B confirmed when Resident 1 expressed he wanted to discharge she had not provided him with a release of liability form and acknowledged, when Resident 1 wanted to discharge, she did not know the procedure or what to do at that time, there was no management to reach out for guidance and she believed allowing him to discharge at night would compromise his safety. LN B concluded that it was Resident 1's right to discharge from the facility. LN B added, because Resident 1 did not discharge as he requested, he might have felt imprisoned, frustrated, and angry.During an interview on 2/20/25 at 4:35 p.m., the Director of Staff Development (DSD) stated if a resident had an order that stated they could make decisions themselves, they should be allowed to discharge from the facility. The DSD stated residents had the right to leave the facility if they wanted to. The DSD stated not allowing a resident to be discharged from the facility, when this was his wish and he is responsible for himself, could result in resident feeling upset and frustrated.A review of the facility's policy and procedure (P&P) titled Discharging a resident without Physician's Approval, revised 10/2022, the P&P indicated .if the resident or representative request discharge without the approval of the attending physician, the resident or the representative (sponsor) will be asked to sign a release of responsibility form.if a resident wishes to be discharged to a setting that does not appear to meet his or her post discharge needs or appears unsafe, the facility will treat this situation similarly to a refusal of care.A review of the facility's P&P titled Resident's Rights, revised 2/2021, the P&P indicated .Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the residents right to .self-determination.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to report a possible financial abuse for one out of two residents sampled for financial abuse (Resident 1), when facility staff suspected financial abuse by Resident 1's Care Giver (CG) that was not reported to law enforcement nor the State Agency (California Department of Health [CDPH]) .This failure could lead to Resident1 experiencing a loss of money and continued financial abuse.Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated an admission date to the facility in 11/2025 with diagnoses of Essential Hypertension (HTN, high blood pressure and Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During an interview on 2/20/26 at 2:31 p.m., the Social Services Director (SSD) stated both she and Resident 1's son felt Resident 1's CG was taking advantage of Resident 1's finances. The SSD stated she suspected there was financial abuse going on and did not feel good about the fact the CG was holding Resident 1's credit card. The SSD stated Resident 1's son thought there was some funny business going on. When asked if this should have been reported as a suspicion of financial abuse, the SSD stated yes. The SSD stated she had not reported the suspected financial abuse because she believed Resident 1 had an emotional attachment to the CG and Resident 1 did not complain about it. The SSD stated not reporting a possible financial abuse could lead to loss of money and continued financial abuse.During an interview on 2/20/26 at 3:11 p.m., the Assistant Director of Nursing (ADON) stated that when Resident 1's son had expressed concerns with Resident 1's credit card being kept by the CG and the CG getting paid while Resident 1 was still at the facility, it warranted further investigation and reporting to the appropriate agencies. The ADON stated not reporting alleged financial abuse to the appropriate agency such as the police, the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) and CDPH could result in continued financial loss and abuse to escalate. ADON stated if staff felt and suspected financial abuse, then it should have been reported so an investigation could be initiated.During a telephone interview on 2/20/26 at 4:53 p.m., Licensed Nurse (LN) B stated she suspected there was financial abuse of Resident 1 when she became aware CG had Resident 1's credit card and she believed CG used Resident 1's credit card. LN B stated these suspicions should have been reported as possible financial abuse. LN B stated at that time she had formed her suspicion of financial abuse, she was not sure if it should have been reported but now realized that it should have been reported to CDPH and the police. LN B stated not reporting this alleged abuse put Resident 1's safety at risk for possible financial abuse to continue.A review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, the P&P indicated .to protect residents from abuse, neglect exploitation and misappropriation of property by anyone including but not necessarily limited to family members, friends, visitors and or any other individual.identify and investigate all possible incidents of abuse, neglect, exploitation and misappropriation of resident's property.investigate and report any allegations within time frames required by federal requirements.A review of All Facilities Letter (an official communication issued by CDPH, sent to health facilities licensed or certified by the CDPH to provide crucial updates, guidance, and regulatory information.) 21-26, dated 7/26/21, indicated, . Mandated Reporting Requirements of Potential Abuse, Neglect, Exploitation, or Mistreatment of Elders or Dependent Adults.facilities must report suspected or known abuse to their local law enforcement agency, long term care (LTC) ombudsman, and [CDPH] district office (DO).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews and record reviews, the facility failed to ensure services provided met professional standards for one out of two residents sampled for professional standards (Resident 2), when Resident 2 was not provided an alternating pressure pad (APP, a specialized medical-grade mattress system designed to prevent and treat pressure ulcers in patients with limited mobility) as prescribed by the physician.This failure put Resident 2 at increased risk of developing or worsening pressure ulcers (PU, localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), which could cause severe pain, and infection.Findings:A review of Resident 2's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated an admission date to the facility in 1/2026 with diagnoses of Unsteadiness in feet and Dysphagia (difficulty swallowing).A review of Resident 2's Physician's Orders indicated an active order for APP mattress to bed ordered on 1/16/26.During an interview on 2/20/26 1:21 p.m., Licensed Nurse (LN) C stated physician's order should be followed. LN C stated if the physician ordered an APP mattress, the facility should provide this mattress for the resident. LN C stated if the physician order was not followed, then it also meant the facility policy was not followed, and residents would be at risk for further skin issues. LN C stated an APP mattress was important to ensure residents do not develop any skin issue or a skin issue does not worsen.During a concurrent observation and interview on 2/20/26 at 1:53 p.m., in Resident 2's room, LN D verified Resident 2 was not on an APP mattress and was on a regular mattress. LN D stated Resident 2 has fragile skin and was at risk for developing PU.During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 2/20/26 at 2:02 p.m., Residents 2's physician's order and Braden (an assessment tool commonly used in health care to assess and document a client's risk for developing pressure) skin score was reviewed. The ADON verified Resident 2 was not on APP mattress although the physician had ordered it on 1/16/26. The ADON verified Resident 2's Braden score was 15, indicating Resident 2 was at risk for PU. The ADON stated since Resident 2 was at risk for PU, using APP mattress was a preventative measure to hopefully prevent development of PU. The ADON stated staff must follow physician's order because that's what we're supposed to do, trust us to follow physician's order so that we could take care of residents' safely. A review of the facility's policy and procedure (P&P) titled Prevention of Pressure Injuries, revised 4/2020, the P&P indicated .select appropriate support surfaces based on resident's risk factors, in accordance with current clinical practice.A review of the facility's P&P titled Administering Medications dated 12/2025, the P&P indicated .medications are administered in accordance with prescribers' orders.A review of the facility's P&P titled Staffing, Sufficient and Competent Nursing, revised 8/2022, the P&P indicated .staff must demonstrate the skills and techniques necessary to care for residents needs including but not limited to skin and wound care.P&P specific to physician orders was requested but was not provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews and record reviews, the facility failed to ensure all drugs were in locked compartments for one out of four medication carts, when a medication cart was unlocked when it was unattended.This failure could result in access to medications by unauthorized people leading to medication theft and unauthorized medication ingestion with a risk of overdose, drug interactions, or severe adverse effects.Findings:During a concurrent observation and interview on 2/20/26 at 5:14 p.m., Licensed Nurse (LN) A left the medication cart in hall 1 unlocked while inside a resident's room. There were no other LN or unlicensed staff present to look after hall 1 medication cart. Upon return to the medication cart, LN A verified she left the cart unlocked and unattended. LN A stated it was the facility's policy to ensure medication carts were always locked when unattended by the LN for the safety of the residents.During an interview on 2/20/26 at 5:20 p.m., the assistant Director of Nursing (ADON) stated medication carts should always be locked when unattended per facility policy. The ADON stated medication carts should be locked if unattended to ensure unauthorized people could not access the medications in the cart which could put the resident's safety at risk.A review of the facility's policy and procedure (P&P) titled Administering Medications, dated 12/2025, the P&P indicated .during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to maintain infection control measures for two out of two residents sampled for infection control concerns (Residents 2 and 3) when:1. three pillows that were on the floor were picked up by the Licensed Nurse (LN) and placed back on Resident 2's bed; and2.the mouthpiece of Resident 3's nebulizer (medical device that converts liquid medication into a fine, breathable mist for direct inhalation into the lungs) was not kept in a clean, dry, and sealed container to prevent cross contamination (happens when bacteria or other germs are unintentionally transferred from one object to another).These failures could put the residents at risk for infection transmission, illness, and worsening of chronic conditions.Findings:1. A review of Resident 2's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated an admission to the facility in 1/2026 with diagnoses of Unsteadiness in feet and Dysphagia (difficulty swallowing.During a concurrent observation and interview on 2/20/26 at 1:53 p.m., in Resident 2's room, LN D was observed, and LN D verified, he picked up three pillows from the floor and placed the pillows at the foot of Resident 2's bed.During a concurrent observation and interview on 2/20/26 at 2:02 p.m., the Assistant Director of Nursing (ADON) verified seeing 3 pillows on Resident 2's foot of bed. The ADON stated anything that fell on the floor was already contaminated and the nurse should not have placed the dirty pillows back on Resident 2's bed. The ADON stated having soiled items, or items from the floor was dirty and could put Resident 2 at risk of infection.A review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Committee (IPCC) revised 7/2016, the P&P indicated .the objectives of IPCC.assist in the development and implementation of written policies and procedures for the prevention and control of infections among residents.provide facility guidelines for a safe and sanitary environment.review, establish and monitor environmental infection prevention and control practices in accordance with Centers for Disease Control (CDC)/ Healthcare Infection Control Practices Advisory Committee (HICPAC)/ Occupational Safety and Health Administration (OSHA) guidelines and local and state requirements. 2. A review of Resident 3's face sheet indicated an admission date to the facility in 12/2022 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) and Emphysema (chronic lung disease that causes shortness of breath)A review of Resident 3's Physician Order Summary (POS, a healthcare professional's written instruction specifying the care, services, treatment, and medications a patient should receive), for 2/2026, indicated an order for a medication solution (liquid) of three milliliter (ml, a unit of measure) to be inhaled via nebulizer every 8 hours.During a concurrent observation and interview on 2/24/26 at 12:00 p.m., in Resident 3's room, Resident 3's nebulizer mouthpiece was kept on top of the bedside dresser, not stored in a container or bag protecting from cross contamination, along with a soda, and a used drinking cup. Resident 3 stated staff would administer his nebulizer medication but would rarely keep the mouthpiece inside the plastic bag.During a concurrent observation and interview on 2/24/25 at 12:05 p.m., in Resident 3's room, LN E verified Resident 3's nebulizer mouthpiece was not kept inside the plastic bag provided to keep the mouthpiece protected after use. LN E stated after use, the mouthpiece should be kept inside the plastic bag per facility policy. LN E stated leaving the mouthpiece on top of the drawer instead of in the protective bag was a cross-contamination issue and could result in Resident 3 getting sick.During a concurrent observation and interview on 2/24/25 at 12:23 p.m., in Resident 3's room, the Director of Nursing (DON) verified the mouthpiece was not kept inside the plastic bag and was on top of Resident 3's bedside dresser. The DON stated this practice was not acceptable as this could put Resident 3's safety at risk. The DON stated after use, the mouthpiece should be kept in the plastic bag (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to prevent cross contamination and prevent infection.A review of the facility's P&P titled Administering Medications Through Small Volume Handheld Nebulizer, dated 12/2025, the P&P indicated .rinse and disinfect the nebulizer equipment according to facility protocol, store in plastic bag with resident name and date on it.