

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 04/30/2026
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of seven sampled residents (Resident 1 and Resident 2) were protected from abuse when profanity and a physical altercation occurred between Resident 1 and Resident 2 during which Resident 2 kicked Resident 1 on the knee. The facility's failure to prevent and promptly intervene in the resident-to-resident altercation placed Resident 1 and Resident 2 at risk for physical harm, emotional distress, and an unsafe environment. Cross reference F658.A review of Resident 1's admission record indicated she was admitted to the facility in October, 2020 with medical diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 4/13/26, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 13 which indicated her cognition was intact (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 SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a COC among the residents) form, dated 3/30/26, indicated she was the victim of a resident-to-resident altercation that started on 3/29/26. The form indicated, Resident [Resident 1] initially had no complaints [no complaints] after incident with another resident [Resident 2] where she was kicked in the L [left] knee. A review of Resident 1's evaluation, type, IDT [interdisciplinary team, typically includes the nursing leadership, social services, and medical records]- Interdisciplinary Post Event Note, dated 3/30/26 at 9:46 a.m., indicated, Resident [Resident 1] with a resident-to-resident incident altercation on 3/26/26 at 1615 [4:15 p.m.]. Incident was witnessed by two [2] CNA [certified nurse assistant] staff as they seen this resident coming up to the nursing station pushing her wheelchair into another resident [Resident 2] who was sitting up at the nurse's station as well. The aggressor [Resident 2] asked this resident [Resident 1] to stop and this resident told the aggressor to 'fuck off' and did not stop pushing into the wheelchair. The resident [Resident 2] then kicked this resident [Resident 1] in the left knee. A review of Resident 2's admission record indicated she was admitted to the facility in July, 2019 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (conditions that affect blood flow to the brain) and heart failure (inability of the heart to pump blood adequately throughout the body). A review of Resident 2's MDS dated [DATE], indicated her BIMS score was 15 which indicated her cognition was intact. A review of Resident 2's SBAR form, dated 3/29/26, indicated, This resident is aggressor and kicked another resident in the knee and was observed doing it. A review of Resident 2's progress notes, type, Alert Note, dated 3/29/26 at 7:16 p.m., indicated, This resident was observed by two (2) CNA kick another resident's knee [Resident 1].Resident stated she kicked her and is admitting to it. During an interview and observation on 4/30/26 at 2:21 p.m., Resident 1 stated she was by the front nurse's (continued on next page)</p>

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
---	-------	-----------

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 04/30/2026
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>station and Resident 2 was in her way. Resident 1 stated Resident 2 kicked her in her left knee in front of everyone, including facility staff. Resident 1 further stated it upset her because it hurt. Resident 1 stated staff did not respond immediately to the incident. Resident 1 stated, I give her the finger, and gestured by raising her middle finger, when she saw Resident 2. During an interview on 4/30/26 at 2:35 p.m., Resident 2 stated she and Resident 1 were by the nurse's station in their wheelchairs and Resident 1 told her, Get the fuck out of my way! Resident 2 further stated Resident 1 continued to yell at her. Resident 2 confirmed facility staff witnessed the incident. Resident 2 stated she kicked toward Resident 1 to get her away from her hitting Resident 1's knee. Resident 2 stated that since the incident she would give Resident 1 the middle finger when Resident 1 passed by her room. Resident 2 stated Resident 1 would sit in the hallway outside of her room and call her, a fucking bitch. During an observation on 4/30/26 at 2:46 p.m. Resident 1 was observed in her wheelchair and stopped in front of Resident 2's doorway. Resident 2 yelled, Keep going! Resident 1 stated, Oh yea! and continued to wheel herself down the hallway. A facility staff member was seated approximately 10 feet (ft.- a unit of measure) away and paid no attention to the interaction that transpired between Resident 1 and Resident 2. During an interview on 4/30/26 at 3:02 p.m., CNA 1 confirmed that she witnessed the resident-to-resident incident that occurred between Resident 1 and Resident 2 by the nurse station. CNA 1 stated Resident 1 had rolled up to the nurse station in her wheelchair and yelled for help for her nurse. CNA 1 stated Resident 2 was already seated in her wheelchair at the nurse's station and that Resident 2 yelled at Resident 1 to go away. CNA 1 stated that Resident 2 then kicked Resident 1 in the knee and that the kick was intentional to get Resident 1 away from her. CNA 1 further stated, [Resident 2] could have verbalized to get her away before deciding to kick her [Resident 1] because she [Resident 2] can let her needs be known, but she just kicked her instead. During an interview on 4/30/26 at 3:25 p.m., Registered Nurse 1 (RN 1) stated that Resident 1 had a history of altercations with other residents. RN 1 confirmed that it was the responsibility of the facility staff to protect all residents from abuse. During an interview on 5/04/26 at 1:49 p.m., the Social Service Director (SSD) stated abuse was physical, financial, verbal, neglect, isolation, withholding medications, or withholding visitations. The SSD stated, If staff noticed the verbal altercation and yelling, they should had separated the resident's immediately. The SSD further stated that she considered the physical contact between Resident 1 and Resident 2 as abuse, Because one of the resident's actually physically touched the other resident and because of the verbal- because they were both cursing at each other. The SSD confirmed that it was the facility's responsibility to protect residents from all forms of abuse. During an interview on 5/04/26 at 2:19 p.m., the Assistant Director to Nursing (ADON) stated abuse was verbal, financial, physical and sexual. The ADON stated the resident-to-resident incident between Resident 1 and Resident 2 was considered verbal and physical abuse. The ADON further stated it was verbal abuse because Resident 1 and Resident 2 were talking vulgarly to each other, and it was considered physical abuse because the kick made physical contact. A review of the facility's policy and procedure titled, Abuse, Neglect, and Exploitation, dated 2025, indicated, It is the policy of this facility to provide protections for health, welfare and rights of each resident. Physical Abuse includes.kicking.Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents.Prevention of Abuse, Neglect and Exploitation.Identifying, correcting and intervening in situations in which abuse.is more likely to occur.Possible indicators of abuse include.Verbal abuse of a resident overheard.Physical abuse of a resident observed. A review of the facility's document titled, Certified Nursing Assistant-Job Description, dated 2020, indicated, Protects residents from abuse. A review of the facility's document titled, Registered Nurse- Job Description, dated 2023, indicated, Protects residents from abuse.</p>		

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 04/30/2026
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)		
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards of practice were met for three of seven sampled residents (Resident 1, Resident 2 and Resident 4) when:1. Following falls, Resident 4's neurological assessments (an assessment of an individual's nervous system following a fall to help identify neurological injuries and measure the severity of damage caused by head trauma), alert charting, and post fall skin assessments were not completed as required by facility policy and nursing standards of practice,2. Resident 4's abnormal neurological assessment findings were not reported to the physician as required, and;3. Following a resident-to-resident abuse allegation, required alert charting was not completed for Resident 1 and Resident 2.These failures placed residents at risk for unrecognized changes in condition (COC), delayed medical interventions, and inadequate monitoring following potential injury and abuse. Cross reference F600 and F684.1. A review of Resident 4's admission record indicated he was admitted to the facility in January, 2026 with medical diagnosis which included multiple fractures of ribs (broken ribs), traumatic subdural hemorrhage (a life-threatening brain injury where blood collects between the dura mater [a protective layer of the brain] and the brain), and repeated falls.A review of Resident 4's evaluation, titled, Social Services- Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment), dated 3/11/26, indicated his BIMS score was 13, which indicated his cognition was intact (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 4's evaluation titled, Nursing-Clinical admission Evaluation Section 5. Fall Risk Evaluation, dated 1/09/26, indicated his risk for falls was moderate.A review of Resident 4's evaluations titled, Nursing- Fall Risk Evaluation, dated 3/09/26, 3/12/26, and 4/06/26 all indicated his risk for falls was high.A review of Resident 4's SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a COC among the residents) forms indicated the following:Dated 1/09/26, The COC, symptoms, or signs observed and evaluated is/are: Falls . Summarize your observations and evaluations: RESIDENT [Resident 4] SELF TRANSFERRED TO RESTROOM.Recommendations of Primary Clinicians [physician]: [staff are expected to] MONITOR.Dated 2/05/26, The COC.Falls.Summarize your observations and evaluations: Witnessed by CNA (Certified Nurse Assistant).he [Resident 4] lost his balance and fell about six (6) inches backwards, back and posterior [referring to the back side of the body] head lightly hitting wall.Recommendations of Primary Clinicians: [staff were expected to] neuro checks and monitor (SIC) [monitor].Dated 2/18/26, The COC.Falls.Summarize your observations and evaluations: PT [patient- Resident 4] FELL ONCE AT 0910 [9:10 a.m.] WITH C/O [complaints of] FEELING DIZZY.FELL AGAIN AT 0940 [9:40 a.m.].Recommendations of Primary Clinicians: [staff were expected to] MD [Medical Doctor] SAID TO MONITOR PER COMPANY POLICY.Dated 3/09/26, The COC.Falls.Skin Evaluation: [was check marked] Not clinically applicable to the COC being reported.Summarize your observations and evaluations: At 1215 [12:15 p.m.] this writer was alerted by the CNA that resident [Resident 4] had fallen and hit his head.Resident [Resident 4] reported head pain.Recommendations of Primary Clinicians: Send to ER [emergency room].Dated 3/12/26, The COC.Falls.Summarize your observations and evaluations: [was left blank].Recommendations of Primary Clinicians: [staff were expected to] MONITOR NVS [neurological vital signs (blood pressure, temperature, pulse, respirations, and oxygen saturation [a measurement of how much oxygen is being carried by red blood cells]). Dated 4/06/26, The COC.Falls. Skin Evaluation: [was check marked] Not clinically applicable to the COC being reported. Summarize your observations and evaluations: [was left blank] .Recommendations of Primary Clinicians: no new order.A review of Resident 4's care plan report indicated the following:Date initiated 1/09/26, [Resident 4] is a high risk for falls. [staff were expected to] Follow facility fall protocol.Date initiated 2/05/26, [Resident 4] had a witnessed (continued on next page)</p>		

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 04/30/2026
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>non-injury fall, hitting head against wall. [staff were expected to] Alert charting every shift x [for] 72 hours.Date initiated 2/19/26, [Resident 4] had an actual fall on with no injury r/t [related to] x2 [twice] with in.10 min [minutes] of each other. [staff were expected to] Continue interventions of the at-risk plan.Neuro checks.Date initiated 3/12/26, The resident [Resident 4] has had an actual fall 3/12/26 with no injury.[staff were expected to] Monitor/document/report PRN [as needed] x 72 h [hour] to MD for s/s [signs and symptoms]: pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation.Neuro-checks PER POLICY.Date initiated 4/06/26, [Resident 4] had a non-injury fall out of bed. [staff were expected to] Alert charting every shift x 72 hours.A review of Resident 4's IDT (interdisciplinary team, typically includes the nursing leadership, social services, and medical records)- Interdisciplinary Post Event Notes indicated the following:Dated 2/06/26, Resident 4 had a fall to the ground and head strike to the wall on 2/05/26. The note further indicated that the MD was notified and alert charting every shift x 72 hours was expected.Dated 2/19/26, at 9:10 a.m. Resident 4 fell on his hip on 2/18/26. Subsequently, Resident 4 fell again on 2/18/26 and he was found on the floor in the middle of the doorway of his room and hallway. The note further indicated that the MD was notified and alert charting and neurological checks were expected.Dated 3/11/26, Resident 4 had a witnessed fall and hit his head on the door on 3/09/26. The note further indicated that the MD was notified and alert charting was expected.Dated 3/16/26, Resident 4 was found on the floor on 3/12/26. The note indicated that the MD was notified and neurological checks were expected.Dated 4/07/26, as per Resident 4, I fell out of bed, on 4/06/26. The note indicated that the MD was notified and alert charting every shift for 72 hours was expected.A review of Resident 4's evaluations titled, Nursing-Neuro Check Evaluation, with dates ranging from 1/10/26 through 4/06/26, indicated that vital signs and neurological assessments were expected to be completed every (q) 15 min x (for) one hour, q 30 min x one hour, q one hour x four hours, q four hours x 24 hour, and q 8 hours x40 hours. Resident 4's neurological assessments indicated the following assessments, and vital signs were not completed:Dated 1/10/26, for two of the q four hours, and one of the q eight hours,Dated 2/05/26, for one of the q eight hours,Dated 3/12/26, for one of the q 30 min, four of the q one hours, two of the q four hours, three of the q eight hours,Dated 3/16/26, for four of the q four hours, six of the q eight hours, and;Dated 4/06/26, for three of the q four hours, and four of the q eight hours.A review of Resident 4 neurological assessments dated 3/09/26 indicated that assessments and vital signs were completed up to the first q one hour only with the last assessment documented at 12:30 p.m.A review of a facility provided document titled, [Name of the Skilled Nursing Facility (SNF)] Census List [Resident 4], indicated on 3/09/26 Resident 4 was discharged to a General Acute Care Hospital (GACH) at 1:11 p.m. and returned to the SNF on 3/10/26 at 4:31 p.m.A review of Resident 4's progress notes dated 1/09/26 at 1 p.m. through 4/09/26 at 12:03 p.m. indicated that progress notes type, Alert Charting, were not completed every shift status post fall for a total of 72 hours.A review of a facility provided document titled, ED [emergency department] Physician Notes, dated 4/08/26 at 4:50 p.m., indicated, .there is a small scratch to his [Resident 4's] left temple [located between the forehead and the ear] area.A review of a GACH provided document titled, [Name of GACH]- Adult Critical Care Consult Note, dated 4/08/26, indicated that Resident 4 was admitted to the GACH on 4/08/26. The document indicated, Skin- comments: Left cheek abrasion [a wound caused by skin rubbing against a rough surface that affects the top skin layer].A review of Resident 4's progress note type, EMAR [electronic medical record]- Administration Note, dated 4/08/26 at 6:55 p.m., indicated, PT [Resident 4] was out at a VA [Veterans Affairs] appointment and his wife was concerned about a bruise on his face from a previous fall on 4/06/26 and took him to the ER at [name of GACH].A review of Resident 4's eMAR dated from 1/09/26 through 4/08/26 indicated no evidence that any changes to Resident 4's skin were assessed, documented, and/or monitored. 2. A review of Resident 4's evaluations titled, Nursing-Neuro Check Evaluation [neurological assessments], indicated the following:Dated 3/12/26, . at 1p.m. Pupil [a circular opening at the center of the iris (color portion of the eye)] Size Bilateral (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[both] [was check marked as] Not Equal [can indicate a serious brain injury and requires emergency medical evaluation] . at 1:30 p.m . Pupil Size Bilateral [was check marked as] Not Equal- RIGHT EYE 1 MM [millimeter- a unit of measure] LEFT 1.5-2 MM. This indicated Resident 4's pupils were documented as unequal for four more consecutive assessments, and;Dated 3/16/26, . at 10:30 a.m . Pupil Size Bilateral [was check marked as] Not Equal- Right pupil is 1 mm.left pupil is 2-2.5 mm. This indicated Resident 4's pupils were documented as unequal for seven more consecutive assessments. A review of Resident 4's eMAR dated from 1/09/26 through 4/08/26 indicated no evidence that any changes to Resident 4's neurological status was reported to the MD.During an interview on 4/30/26 at 10:27 a.m., the Administrator (ADM) stated that she had no knowledge of a fall or any injury to Resident 4's face prior to him leaving the facility on 4/08/26 for an appointment. The ADM confirmed that Resident 4 had a fall on 4/06/26 and further stated he could had possibly developed a bruise later. The ADM stated that she expected any changes to Resident 4 skin to be documented as a skin assessment or in his progress notes.During an interview and concurrent record review on 4/30/26 at 10:56 a.m., Licensed Nurse 2 (LN 2) confirmed that Resident 4 had multiple falls while admitted to the facility in 2026. LN 2 further confirmed that he transferred Resident 4 to a GACH on 3/09/26 status post-fall because he had a knot (a lump that is usually a localized hematoma [a collection of clotted blood]) from the fall on the top, right-side of his head and complained of head pain. LN 2 stated the knot should have been documented under Resident 4's evaluation forms [which included the SBAR] or in his progress notes as a skin assessment, especially since he complained of pain. LN 2 reviewed Resident 4 SBAR dated 3/09/26 and confirmed the knot he observed on Resident 4's head [which indicated a change to skin] was not documented. LN 2 stated the protocol for neuro check evaluations was that they were completed q 15 min for the first hour, q 30 min for an hour, q 1 hour for four hours, q 4 hours for a whole day, and q 8 hours until the time frame hit 72 hours post fall. LN 2 confirmed neuro checks were expected to be completed for a total of 72 hours. LN 2 stated the purpose of conducting neuro checks was to ensure the resident was not experiencing visual changes, pain, or abnormal vital signs. LN 2 further stated the purpose of the form was, To maintain there are no delayed reactions and to make sure they [the residents] are stable and ok. LN 2 confirmed that it was expected for Licensed Staff to notify the MD immediately if the resident's pupils were not equal or reactive to light. LN 2 further stated the purpose of the neurological assessments was, To make sure there is no further injury, like a brain bleed. LN 2 reviewed Resident 4's neuro check evaluations and confirmed the documentation of his unequal pupils should have been reported to the MD and documented as a progress note or in the neuro check evaluation. LN 2 stated when a resident had a COC, thereafter, the resident was placed on 72-hour monitoring and verified that was considered alert charting. LN 2 confirmed that alert charting was expected to be completed every shift for a total of 72 hours. LN 2 stated the purpose of alert charting was to keep them [nursing staff] informed of any updates or if the staff needed to review how the resident was the day before or prior shift if changes were noted and the MD required notification. LN 2 further stated the purpose of alert charting was, To compare and see if there are any other interventions they need to do. LN 2 confirmed that morning shift (AM) was from 6:30 a.m. through 3p.m., evening shift (PM) from 2:30 p.m. through 11 p.m., and night shift (NOC) was from 10:30 p.m. through 7 a.m.During an interview on 4/30/26 at 11:29 a.m., CNA 2 confirmed she accompanied Resident 4 to his doctor's appointment on 4/08/26. CNA 2 stated Resident 4's wife met them at his doctor's appointment. CNA 2 further stated Resident 4's wife noticed that one side of his face was discolored and red. CNA 2 stated that is when Resident 4's wife was informed of the fall that occurred that morning. CNA 2 stated at that time, she did notice discoloration on one side of Resident 4's face. CNA 2 believed that the discoloration was on the left side of Resident 4's face. CNA 2 described the discoloration as reddish-pinkish in color. CNA 2 stated Resident 4 verbally expressed to his wife that his head hurt. CNA 2 further stated Resident 4's wife wanted him to go to a GACH.During an interview on 4/30/26 at 11:45 a.m., LN 1 confirmed the protocol for neuro checks was that they were completed for a period of 72 hrs. LN 1 stated the (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>purpose of neuro checks was, To make sure there are no brain bleeds, neurological problems, no pain, and should anything happen, to ensure staff is responsive in time. LN 1 further stated if a resident was noted to have unequal pupils during a neuro check evaluation the expectation was that the MD was called immediately. LN 1 stated, They [the resident] could have a brain bleed and the neurological system is going down. It could do a lot of damage. LN 1 stated after a resident had a COC alert charting started. LN 1 further stated alert charting was required to be completed every shift for four to five days. LN 1 stated she was unsure of the length of time but verified that alert charting was conducted every shift. LN 1 stated alert charting let the whole team [care staff] know what was going on with the resident. LN 1 confirmed that Resident 4 had multiple falls during his 2026 admission to the facility. LN 1 further stated, I feel like there could have been more that should have been done. During an interview and concurrent record review on 4/30/26 at 1 p.m., the ADM reviewed Resident 4's neuro check assessment dated [DATE] and verified that his neuro evaluation should have been continued when he returned from the GACH on 3/10/26 because it was still within the 72-hour time frame. The ADM stated the purpose of completing the neuro check evaluation was, To check for any type of adverse event from the fall. The ADM further stated it was expected that any abnormal findings from the neuro check assessment were reported to the MD. The ADM reviewed all of Resident 4's 2026 neurological check evaluations and confirmed that they were not completed as expected. The ADM further confirmed the neurological check evaluations dated 3/12/26 and 3/16/26 contained abnormal findings that should have been reported to the MD. The ADM reviewed Resident 4's progress notes and confirmed that she could not find evidence that the MD was informed. The ADM stated after a resident had a COC they were placed on alert charting for 72 hours. The ADM stated nursing staff were expected to complete alert charting every shift. The ADM further stated, One of the main purposes is to assess how the resident is doing. It's an alert to check on them and to inform the MD if there are any changes. The ADM reviewed Resident 4's progress notes type, Alert Charting, and confirmed the following: No alert charting was completed NOC shift on 1/10/26, 1/12/26, and 2/5/26 - 2/7/26, No alert charting was completed AM, PM, and/or NOC shift on 2/18/26 - 2/22/24, No alert charting was completed PM shift on 3/12/26, No alert charting was completed AM, PM, and/or NOC shift on 3/15/26, and No alert charting was completed NOC shift on 4/6/26 and 4/7/26. Subsequently, the ADM stated if a resident experienced a change in skin the expectation was that the change was documented in the SBAR, as a progress note, or skin assessment, and that further monitoring was initiated. The ADM reviewed Resident 4's eMAR and confirmed no skin assessments or progress notes were completed that reflected the skin changes observed by staff. The ADM was given the opportunity to provide documented skin assessments for Resident 4 and no evidence was provided. 3. A review of Resident 1's admission record indicated she was admitted to the facility in October 2020 with medical diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's MDS dated [DATE], indicated her BIMS score was 13 which indicated her cognition was intact. A review of Resident 1's SBAR form, dated 3/30/26, indicated she was the victim of a resident-to-resident altercation that started on 3/29/26. The form indicated, Resident [Resident 1] initially had not complaints [no complaints] after incident with another resident [Resident 2] where she was kicked in the L [left] knee. A review of Resident 1's evaluation, type, IDT- Interdisciplinary Post Event Note, dated 3/30/26 at 9:46 a.m., indicated, Resident [Resident 1] with a resident-to-resident incident altercation on 3/26/26 at 1615. Interventions at time of Event [staff were expected to] .Alert Charting initiated. A review of Resident 1's care plan report dated 3/29/26, indicated, [Resident 1] was involved in a resident-to-resident incident. Interventions [staff were expected to] .3/29/26: Alert charting initiated every shift x 72 hours. A review of Resident 1's progress notes dated 3/29/26 at 11:10 p.m. - 4/3/26 at 5:04 p.m. indicated that progress notes type, Alert Charting, was not completed every shift status post resident-to-resident abuse allegation for a (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>total of 72 hours.A review of Resident 2's admission record indicated she was admitted to the facility in July 2019 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (conditions that affect blood flow to the brain) and heart failure (inability of the heart to pump blood adequately throughout the body).A review of Resident 2's MDS dated [DATE], indicated her BIMS score was 15 which indicated her cognition was intact. A review of Resident 2's SBAR form, dated 3/29/26, indicated, This resident is aggressor and kicked another resident in the knee and was observed doing it.A review of Resident 2's evaluation, type, IDT- Interdisciplinary Post Event Note, dated 3/30/26 at 10:23 a.m., indicated, Resident [Resident 2] with a resident-to-resident incident altercation on 3/26/26 at 1615.Interventions at time of Event [staff were expected to] .Alert Charting initiated.A review of Resident 2's care plan report dated 3/29/26, indicated, [Resident 2] is involved in an incident as where [Resident 2] is the aggressor and kicked another resident's knee.Interventions [staff were expected to] .3/29/26: Alert charting initiated every shift x 72 hours.A review of Resident 2's progress notes dated 3/29/26 at 7:16 p.m. through 4/3/26 at 11:54 a.m. indicated that progress notes type, Alert Charting, was not completed every shift status post resident-to-resident abuse allegation for a total of 72 hours.During a phone interview on 5/04/26 at 1:49 p.m., the Social Service Director (SSD) stated, With any type of abuse, extra documentation is expected so they [staff] can monitor what is going on.During a phone interview and concurrent record review on 5/4/26 at 2:19 p.m., the Assistant Director to Nursing (ADON) stated alert charting is expected for 72 hours every shift after an allegation of abuse. The ADON further stated nurse staff were expected to complete a narrative note documenting any change in behavior, or ill effects towards the incident. The ADON stated, The purpose is ongoing monitoring to ensure that they [staff] are keeping an eye on them (residents) and also documenting that they are keeping an eye on them. The ADON reviewed Resident 1 and Resident 2's progress notes post resident-to-resident allegation dated 3/29/26 and confirmed that alert charting was not completed every shift for 72 hours.A review of the facility's policy and procedure (P&P) titled, Neurological Assessment, dated 2021, indicated, Neurological assessment is conducted to evaluate the resident for changes that may be indicated of neurological injury.Conduct neurological checks as frequently as ordered.Documentation.The following is recorded in the resident's medical record: The date and time the procedure was performed.Assessment data obtained during the procedure.Reporting.Notify the physician of any change in a resident's neurological status.Report other information in accordance with facility policy and professional standards of practice.A review of the facility's P&P titled, Charting and Documentation, dated 2025, indicated, Services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record.A review of the facility's P&P titled, Resident Examination and Assessment, revised 2025, indicated, Reporting.Notifying the physician/nurse practitioner of any abnormalities such as:.change in.neurological status from baseline.wounds.on the resident's skin.Report other information in accordance with facility policy and professional standards of practice.A review of the facility's P&P titled, Falls - Clinical Protocol, revised 2025, indicated, Monitoring and Follow-Up.The staff will monitor the individual's response to interventions intended to reduce falling or the consequences of falling.A review of the facility's P&P titled, Safety, revised 2025, indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.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.The type and frequency of resident supervision may vary among residents and over time for the same resident.A review of the facility's policy and procedure titled, Abuse, Neglect, and Exploitation, dated 2025, indicated, Prevention of Abuse.ongoing assessment.and monitoring of residents with needs and behaviors which might lead to conflict or neglect.Protection of Resident.Increased supervision of the alleged victim (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and residents.A review of the facility's document titled, Registered Nurse- Job Description, dated 2023, indicated, Major Duties and Responsibilities.Ensures that policies and procedures are complied with by nursing personnel assigned.Assesses for changes in resident's status, notifying the physician and resident's family or representative and documenting accordingly.Reports any incidents or unusual occurrences to the unit manager, assistant director of nursing or the director of nursing.</p>		

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 04/30/2026
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to provide quality of care for one of seven sampled residents (Resident 4) when a fall was not documented in his medical record, and the facility's fall protocol was not initiated status post (after) fall. Cross reference F658. These failures resulted in an unaddressed head injury, inadequate monitoring and implementation of the facility's fall protocol, and a delay in care for Resident 4. A review of Resident 4's admission record indicated he was admitted to the facility in January, 2026 with medical diagnosis which included multiple fractures of ribs (broken ribs), traumatic subdural hemorrhage (a life-threatening brain injury where blood collects between the dura mater [a protective layer of the brain] and the brain), and repeated falls. A review of Resident 4's evaluation, titled, Social Services- Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment), dated 3/11/26, indicated his BIMS score was 13, which indicated his cognition was intact (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 4's SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a COC among the residents) form, dated 3/09/26, indicated that Resident 4 had a witnessed fall and hit his head. The form indicated that Resident 4 was sent to an emergency department of a General Acute Care Hospital (GACH). A review of a facility provided document titled, [Name of GACH]- Hospitalist History and Physical, dated 3/09/26, indicated, ER [emergency room] course: He [Resident 4] was transferred to our hospital for neurosurgical [a specialty concerned with surgical treatments of disorders that affect the nervous system (the brain, spinal cord, and nerves)] consultation he had a repeat CT [computed tomography- an imaging procedure] scan done it showed acute on chronic subdural hematoma [when fresh bleeding occurs on older blood between the brain and its outer covering] there is a four (4) mm [millimeter- unit of length] shift [indicated that brain tissue moved from its center line] neurosurgery was consulted observation recommended. A review of a facility provided document titled, Skilled Nursing Facility [SNF] Transfer Orders, dated 3/10/26, indicated Resident 4 was in stable condition and was transferred back to the skilled nursing facility on 3/10/26. A review of a GACH provided document titled, [Name of GACH]- Hospital Emergency Department ED Provider Note, dated 4/08/26, indicated, Pt [patient- Resident 4] reports that at nine (9) a.m. he had an unwitnessed fall at his SNF. There was a positive head strike. A review of a hospital provided document titled, [Name of GACH]- Adult Critical Care Consult Note, dated 4/08/26, indicated that Resident 4 was admitted to the GACH on 4/08/26. The document indicated, [Resident 4] had a fall in March and sustained a subdural hematoma. but presented to the emergency at [name of GACH] after an unwitnessed fall in the SNF. The patient [Resident 4] hit his head. Patient [Resident 4] was transferred for a new subdural hematoma. The document further indicated, [Resident 4].with an enlarging left sided subdural hematoma that now has mass effect [damage and displacement of normal brain tissue], brain compression [a life-threatening emergency where increased intracranial (within the skull) pressure causes the brain to be squeezed] and shift. Imaging. The subdural hematoma is dramatically larger than it was on his initial presentation on March 9. A review of Resident 4's SNF electronic medical records (eMAR), dated 4/08/26, indicated no evidence that a fall was reported or documented on 4/08/26. Resident 4's eMAR dated 4/08/26 also indicated no evidence of: A status post fall assessment, MD notification, Emergency contact notification, Alert charting, and; An updated care plan. During an interview on 4/30/26 at 11:29 a.m., Certified Nurse Assistant 2 (CNA 2) confirmed she accompanied Resident 4 to his doctor's appointment on 4/08/26. CNA 2 stated that earlier that day, CNA 3 asked her for help to pick Resident 4 off the floor. CNA 2 stated Resident 4's nurse, and named Licensed Nurse 1 (LN 1), had also responded and they assisted him back into bed from a crouched position. CNA 2 verified that Resident 4 was in a crouched position by his bed at the time she responded to assist. CNA 2 stated when she accompanied Resident 4 to his appointment later that (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>day, his wife met them at his doctor's appointment. CNA 2 further stated Resident 4's wife noticed that one side of his face was discolored and red. CNA 2 stated that is when Resident 4's wife was informed of the fall that occurred that morning. CNA 2 stated that at that time, she did notice discoloration on one side of Resident 4's face. CNA 2 believed that the discoloration was on the left side of Resident 4's face. CNA 2 described the discoloration as reddish-pinkish in color. CNA 2 stated Resident 4 verbally expressed to his wife that his head hurt. CNA 2 further stated Resident 4's wife wanted him to go to a hospital. During an interview on 4/30/26 at 11:45 a.m., LN 1 stated that she did not remember if Resident 4 experienced a fall on 4/08/26. LN 1 further stated known falls were expected to be documented as an SBAR. LN 1 stated status post fall, the resident was evaluated to ensure he/she was not hurt, and the MD (medical doctor) was notified. LN 1 stated MD recommendations were to be documented and carried out by staff. During a phone interview on 4/30/26 at 12:11 p.m., CNA 3 stated on 4/08/26 Resident 4 yelled for help from inside of his room. CNA 3 stated, When I went into his room he was on the floor next to his bed, and when I asked him what happened, he told me he fell. CNA 3 confirmed Resident 4 was observed on the floor by his bed. CNA 3 stated she retrieved Resident 4's nurse and that the nurse assessed him. CNA 3 stated she did not recall the name of Resident 4's nurse that assisted. CNA 3 stated she left the room after the nurse arrived. During an interview on 4/30/26 at 12:18 p.m., the Administrator (ADM) confirmed that LN 1 was Resident 4's licensed nurse on 4/08/26 for day shift (6:30 a.m. - 3 p.m.). Subsequently, LN 1 was interviewed again and stated she did not recall Resident 4 falling on 4/08/26. LN 1 further stated, A lot happens every day and I just don't recall. During an interview and concurrent record review on 4/30/26 at 1 p.m., the ADM stated that she expected every resident fall to be reported as a change in condition and that the fall protocol was followed to ensure appropriate monitoring for the resident. The ADM confirmed that she was not aware that Resident 4 experienced a fall on 4/08/26. The ADM confirmed there was no documentation in Resident 4's eMAR that indicated he had fallen on 4/08/26. A review of the facility's policy and procedures (P&P) titled, Quality Care, revised 2025, indicated, Residents will be provided with care and services that may attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Employees are responsible for following established policies and procedures. A review of the facility's P&P titled, Falls- Clinical Protocol, revised 2025, indicated, The staff will evaluate and document falls that occur while the individual is in the facility, including when and where it happened, any observation of events, etc .the staff and IDT [interdisciplinary team, typically includes the nursing leadership, social services, and medical records] will identify pertinent interventions to try to prevent subsequent falls and address the risks of serious consequences. The staff, with the physician's guidance, will follow up on any fall with associated injury. The staff will monitor the individual's response to interventions intended to reduce falling. A review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 2025, indicated, Our facility shall notify the resident, his or her Attending Physician on call/NP [Nurse Practitioner]/PA [Physician Assistant], and representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's Attending Physician/physician on call/NP/PA when there has been a (an): accident or incident involving the resident. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A review of the facility's P&P titled, Charting and Documentation, revised 2025, indicated, .any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Documentation information in a resident medical record can include: Events, incidents or accidents involving the resident. A review of the facility's P&P titled, Documentation in Medical Record, dated 2026, indicated, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. A review of the facility's P&P titled, Care Plans, Comprehensive, revised 2025, indicated, Assessments of residents are ongoing and care plans are (continued on next page)</p>		

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 04/30/2026
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revised as information about the residents and the residents conditions change. A review of the facility's document titled, Registered Nurse- Job Description, dated 2023, indicated, Major Duties and Responsibilities.Ensures that policies and procedures are complied with by nursing personnel assigned.Assesses for changes in resident's status, notifying the physician and resident's family or representative and documenting accordingly.Reports any incidents or unusual occurrences to the unit manager, assistant director of nursing or the director of nursing.</p>		