

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                                                 |
| F 0585<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on interview and record review, the facility failed to ensure eight out of eight sampled residents (Resident 7, Resident 25, Resident 53, Resident 59, Resident 69, Resident 90, Resident 94 &amp; Resident 95) were aware of how to file a grievance and had their complaints resolved when the facility had no current grievance process or appointed officer. In addition, complaints brought up during resident council meetings were not being tracked or responded to. This failure resulted in all eight residents feeling frustrated with the lack of facility response to their complaints. During a Resident Council Meeting on 1/07/26 at 11:00 a.m. in the dining hall, all eight residents present could not describe what the current grievance process was. The entire group expressed frustration with the lack of response to various concerns that had been brought up repeatedly. One resident stated that since the last Social Services Director left there had been no follow up on complaints or grievances. A review of resident council notes from 11/25 and 12/25 indicated there were multiple complaints about cold food and Certified Nursing Assistant (CNA) behavior in the dining hall with no facility or department response documented. During an interview on 1/07/26 at 1:03 p.m., the Activities Director (AD), stated she did her best to meet the resident's needs but currently there was no clear grievance process. During an interview on 1/08/26 at 2:45 p.m., the Assistant Director of Nursing (ADON) stated the Social Services Director was the grievance officer but they did not have one currently and could not provide documentation of tracking facility responses to grievances. The ADON further stated that this could lead to negative outcomes, residents' needs not being met and could make residents feel upset and unheard. A review of the facility policy titled, Grievances/Complaints, Filing, revised in 10/2025, indicated the Administrator had delegated the responsibility of grievance and/or complaint investigation to the grievance officer who was the Social Services Director/designee. It also indicated, Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report to the Administrator within 5 days. The Resident or person filing the grievance or complaint will be informed of the findings of the investigation and the actions that will be taken to correct identified problems. The results of all grievances will be maintained on file.</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<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                 |
| <p>F 0645</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review Level II evaluation (PASRR-following a Level 1 screening, the Level 2 evaluation determines appropriate placement of an individual with a serious mental illness, considering the least restrictive setting, and whether specialized services are needed) was completed for three of six sampled residents (Resident 23, Resident 41, and Resident 68), based on each Resident's documented psychiatric diagnoses and functional status. This failure had the potential for Resident 23, Resident 41, and Resident 68 to receive inappropriate and ineffective care/treatment, or to be inappropriately placed in a long-term care facility. During a review of the Resident 23's admission Record, it indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including diabetes (a chronic condition where the body has trouble regulating blood sugar (glucose)), major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and significant impairment in daily life), anxiety disorder (mental health conditions marked by intense, persistent, and excessive worry or fear about everyday situations, leading to significant distress and impairment in daily life), bipolar disorder (a mental illness causing extreme shifts in mood, energy, and activity), and age-related cognitive decline. During a record review of Resident 23's Minimum Data Set (MDS - an assessment screening tool), dated 12/31/24, active diagnoses included anxiety disorder, depression, and bipolar disorder.</p> <p>During a review of Resident 23's PASRR Level I Screening, dated 9/18/24, it indicated Resident 23 required a PASRR Level II screening due to Positive for SMI [serious mental illness].</p> <p>During a review of the California Department of Health Care Services (DHCS) correspondence to the facility with the subject, Notice of Attempted Evaluation, dated 9/18/24, the DHCS wrote that after speaking with facility staff, a PASRR Level II examination was not scheduled for Resident 23 due to, the individual has no serious mental illness (SMI), and no functional limitations on the last 6 months.</p> <p>During a review of Resident 23's, Progress Notes, dated 4/25/25 at 12:52 a.m., it indicated Resident 23 had displayed, angry outbursts, and was acting aggressively in the facility, and Resident 23's family had reported a history of similar behaviors.</p> <p>During a review of Resident 23's Progress Notes, dated 6/28/25 at 4:59 a.m., it indicated Resident 23 directly touched a direct care staff in an inappropriate sexual manner.</p> <p>During a review of Resident 23's Care Plan Report, initiated on 8/31/24, it indicated the focus item, [Resident 23] has little or no activity involvement r/t [related to] anxiety, depression, disinterest.</p> <p>During a review of Resident 41's admission Record, it indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (hemiplegia is complete paralysis of one side of the body, while hemiparesis is weakness on one side), depression, and schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (like hallucinations, delusions, disorganized thinking) with a mood disorder (major depression or bipolar mania)).</p> <p>During a record review of Resident 41's Minimum Data Set, dated [DATE], it indicated Resident 41 had active diagnoses of depression and bipolar disorder.<br/>(continued on next page)</p> |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                 |
| <p>F 0645</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>During a review of Resident 41's PASRR Level I Screening, dated 9/18/24, it indicated Resident 41 required a PASRR Level II screening due to Positive for SMI.</p> <p>During a review of California DHCS correspondence to the facility with the subject, Notice of Attempted Evaluation, dated 9/18/24, the DHCS wrote that after speaking with facility staff, a PASRR Level II examination was not scheduled for Resident 41 due to, the individual has no serious mental illness (SMI) .no functional limitations on the last 6 months.</p> <p>During a review of Resident 41's, Progress Notes, dated 10/27/25 at 4:39 a.m., it indicated Resident 41 had displayed numerous behaviors primarily stemming from being challenged by people or things.</p> <p>During a review of Resident 41's, Progress Notes, dated 11/1/25 at 12:51 p.m., it indicated Resident 41 engaged in a hostile verbal altercation with another facility resident.</p> <p>During a review of Resident 41's Progress Notes, dated 11/3/25 at 2:12 p.m., it indicated Resident 41, has been exhibiting behaviors that present a danger to himself and/or others, and new psychiatric medications to manage these behaviors had been ordered by Resident 41's physician.</p> <p>During a review of Resident 41's, Care Plan Report, initiated on 10/23/25, it indicated the focus item, [Resident 41] has a psychosocial well-being problem r/t schizophrenic disorder bipolar type.</p> <p>During an interview on 1/06/25 at 1:30 p.m. the MDS Coordinator (MDSC) indicated hospitals that refer residents to the facility for long-term care often did not fill out the PASRR correctly in regard to mental health concerns. The MDSC also indicated it was the responsibility of the Inter-Disciplinary Team (IDT- a group of different professionals (doctors, nurses, therapists, social workers, etc.) collaborating to provide holistic patient care, especially in healthcare settings) to ensure that a resident with a mental illness was correctly re-screened for PASRR, if a mental illness was discovered or newly diagnosed.</p> <p>During an interview on 1/08/25 at 1:25 p.m., the Assistant Director of Nursing (ADON) stated examples of functional limitations for serious mental illness included not getting along with other residents, not caring for oneself, and refusing care/treatment, and/or medications. The ADON also stated it was important the PASRR process was correctly completed, so that residents with serious mental illness were not inappropriately placed in long-term care and skilled nursing facilities. Lastly, the ADON stated the facility's nursing staff was responsible for ensuring PASRR's were completed accurately, and if there was a change in condition, a new PASRR screening was initiated.</p> <p>During a review of the Resident 68's admission Record, it indicated Resident 68 was admitted to the facility on [DATE] with a diagnosis of Schizoaffective Disorder, Bipolar Type (a mental illness causing extreme shifts in mood, energy, and activity, from manic highs (euphoria, high energy, irritability) to depressive lows (sadness, hopelessness, low energy)) dated 7/25/25. During a record review of Resident 68's MDS dated [DATE], it indicated, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The answer to the question was recorded as, 0 indicating, No. Review of Resident 68's MDS section I &amp;ndash; Active Diagnoses - Psychiatric / Mood Disorder, indicated the following diagnoses, I6000. Schizophrenia (e.g., Schizoaffective .disorders [a serious, chronic brain disorder that disrupts how a person thinks, feels, and behaves]).</p> <p>During a review of Resident 68's PASRR Level I Screening, dated 8/01/25, it indicated Resident 68 (continued on next page)</p> |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                 |
| <p>F 0645</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>required a PASRR Level II screening due to Positive for SMI [serious mental illness].</p> <p>During a review of California DHCS correspondence sent to the facility with the subject, NOTICE OF PASRR LEVEL I SCREENING RESULTS, dated 8/01/25, it indicated the results for Resident 68, Re: A SERIOUS MENTAL ILLNESS (SMI) LEVEL II MENTAL HEALTH EVALUATION IS REQUIRED .Your Level I screening indicates that a SMI Level II Mental Health Evaluation is required.</p> <p>During a review of California DHCS correspondence to the facility with the subject, Notice of Attempted Evaluation Re: UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI), dated 8/05/25, the DHCS wrote that a SMI Level II Mental Health Evaluation was not scheduled for the following reason, Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. The case is now closed. To reopen, the facility must resubmit a new level I Screening.</p> <p>During a review of Resident 68's Care Plan Report, initiated 7/25/25, it indicated the focus item, [Resident 68] uses psychotropic medications (Haloperidol [a typical antipsychotic medication used to treat psychotic disorders such as Schizophrenia]) used to treat r/t [related to] schizoaffective disorder. Another focus item initiated 7/28/25 indicated, [Resident 68] has a psychosocial well-being problem.</p> <p>During an observation on 1/05/26, at 12:54 p.m., Resident 68 was heard swearing at facility staff when they were delivering his meal tray.</p> <p>During an interview on 1/05/26, at 1:39 p.m., the Assistant Activities Director (AAD), stated she was assigned to sit outside Resident 68's room for 1:1 supervision due to his history of conflict, aggressive interactions, and behaviors with other residents including his roommates and staff. The AAD stated Resident 68 had issues getting along with his roommates and had room changes due to this issue.</p> <p>During an interview on 1/06/25 at 1:35 p.m., the MDSC indicated she was a resource to staff for PASSR processes. When queried about the reason Resident 68 did not receive a Level II PASRR screening after the facility received his positive Level I PASRR screening results on 8/01/25 indicating he required a Level II PASRR screening, the MDSC replied that she did not know the answer, but she would look into it. Later, the MDSC returned to provide a new Level I PASRR screening, dated 1/06/25, to restart the PASRR screening process for Resident 68, with no further information explaining why the initial PASRR Level II screening process was never completed after the facility was notified by DHCS Resident 68 required a PASRR Level II screening on 8/01/25.</p> <p>During an interview on 1/08/25 at 1:55 p.m., the ADON stated it was important that the PASRR process was correctly completed, so that residents with serious mental illness were not inappropriately placed in long-term care and skilled nursing facilities. When queried why Resident 68's PASRR Level II Screening was not completed after receiving his positive PASRR Level I Screening results on 8/01/25, approximately six days after his admission to the facility on 7/25/25, she replied she did not know, and said it should have been completed to ensure he was not inappropriately placed in the facility and to ensure he received any additional services he may have needed.</p> <p>A review of the undated facility policy and procedure titled, Pre-admission Screening and Resident Review (PASRR), indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening (continued on next page)</p> |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                 |
| F 0645<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | and Resident Review (PASRR) process. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASRR representative for the level II (evaluation and determination) screening process. Upon completion of the level II evaluation, the State PASRR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                                                 |
| <p>F 0712</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide face-to-face and in-person physician visits at least once every 60 days for six (6) of 12 sampled residents (Residents 5, 19, 23, 41, 98, and 99). This deficient practice had the potential to result in a decline in medical, health or psychosocial conditions and a delay in necessary care, treatment and services. A review of Resident 19's admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cellulitis (a bacterial skin infection causing red, swollen, warm, and painful skin that spreads quickly, often from bacteria entering a cut or wound), essential hypertension (high blood pressure), acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body), and spinal stenosis (the narrowing of spaces within the spine, putting pressure on the spinal cord and nerves, causing pain, numbness, weakness, or cramping, often in the lower back, legs, neck, or arms). A review of Resident 19's physician notes indicated she had only had virtual visits with Physician A in the past 90 days.</p> <p>During an interview on [DATE] at 1:46 p.m., with Resident 19 in her bedroom, Resident 19 was on the verge of tears, and stated she had not seen a doctor except on the screen. Resident 19 stated she was unsatisfied with her medical care and wished to go home.</p> <p>A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including rhabdomyolysis (a serious condition where damaged muscle tissue breaks down, releasing harmful substances into the blood, which can lead to kidney failure), sepsis (the body's extreme response to an infection that damages its own tissues and organs, potentially leading to septic shock, organ failure, and death), and paraplegia (paralysis affecting the lower half of the body, typically from the waist down, resulting from damage to the spinal cord, leading to loss of movement and sensation). A review of Resident 5's physician notes indicated he had only seen the facility physician once, and it was virtually, since his admission to the facility.</p> <p>A review of Resident 23's admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including heart failure (condition where the heart can't pump enough blood and oxygen to meet the body's needs), and diabetes mellitus (impaired ability to metabolize blood sugar). Review of Resident 23's physician notes indicated he had only had virtual visits with Physician A in the past 90 days.</p> <p>A review of Resident 41's admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (a bone infection that occurs when germs enter the bone from an injury, surgery, or open wound, leading to pain, swelling, redness, fever, and fatigue), and schizoaffective disorder (a serious mental illness blending symptoms like hallucinations or delusions with depression or mania), and syncope and collapse (fainting/sudden falling). A review of Resident 41's physician notes indicated he had only had virtual visits with Physician A in the past 90 days.</p> <p>Documentation of in-person physician visits for Residents 5, 19, 23, and 41 was requested from both Physician A (facility physician) and the facility, but they were not provided.</p> <p>During a record review on [DATE] at 9:49 a.m., Resident 98's face sheet indicated Resident 100 was admitted to the facility on [DATE] with multiple diagnoses including but not limited to heart failure, coronary artery disease (cholesterol build-up on the inside of the vessels that bring blood to the heart (continued on next page)</p> |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                 |
| <p>F 0712</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>muscle), end-stage kidney disease (the kidneys can no longer function adequately, requiring dialysis or a kidney transplant for survival), diabetes mellitus, left above-the-knee amputation, and an implanted defibrillator (a device implanted in the chest that delivers electrical shocks or pacing to correct life-threatening, abnormal heart rhythms). Review of Resident 98's physician notes indicated he had only had virtual visits with Physician A.</p> <p>During a record review on [DATE] at 10:08 a.m., Resident 98's hospital records indicated that Resident 98 had died at a nearby hospital in the intensive care unit on [DATE].</p> <p>During a record review on [DATE] at 2:45 p.m., Resident 99's face sheet indicated Resident 99 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy (brain dysfunction from a chemical imbalance, often due to severe illness), paralysis on the left side following a cerebral infarct (stroke, a blockage that stops blood flow to the brain), intractable epilepsy (seizures that continue despite anti-seizure medications), coronary artery disease, and heart attack. Review of Resident 99's nurse progress note dated [DATE] indicated Resident 99 had been admitted to comfort care (care team will focus on the patient's comfort while allowing natural death rather than attempting to cure disease) after readmission from the hospital. Review of Resident 99's nurse progress note dated [DATE] indicated Resident 99 had died. Review of Resident 99's physician notes indicated he had only had virtual visits with Physician A in the facility since [DATE].</p> <p>Documentation of physician visits that were in-person were requested but not provided for Residents 98 and 99.</p> <p>During an interview on [DATE] at 12:35 p.m., the Administrator (ADM) stated Physician A was in the building every Monday for an hour, and stated that while he was here he did rounds, but then did paperwork at her (ADM's) desk with someone who transcribed and then Physician A signed. ADM stated Physician A did virtual visits as well. ADM stated that since there were four hallways, Physician A would see one hall each week, for a total of four halls each month. ADM stated Physician A had always done it this way for as long as she had been here. ADM verified there were over 20 residents on each hall and Physician A could not see every patient on the hallway and do a physical exam in an hour. ADM stated that was why he did the virtual visits. ADM stated Physician A was the physician for almost the whole building.</p> <p>During a phone interview on [DATE] at 12:58 p.m., Physician A stated he saw his patients every Monday. Physician A stated he saw his patients in-person or virtually. Physician A stated the number of patients he saw while he was at the facility varied considerably, depending if the nurses had a patient they were concerned about, or sometimes he saw a whole wing. Physician A stated he had 85 or 90 patients in the facility and he came on Mondays during the noon hour.</p> <p>During a review of the undated facility's policy and procedure titled, Physician Services, it indicated The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident .Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA [the Omnibus Budget Reconciliation Act-U.S. Congressional laws that bundle various budget-related changes, notably establishing federal nursing home standards] regulations.</p> |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                 |
| <p>F 0804</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, the facility failed to provide food at a palatable temperature for three of eight sampled residents (Resident 90, Resident 7, &amp; Resident 53) at a confidential resident council interview. This failure had the potential to cause loss of appetite and weight loss in a vulnerable population when food is too cold to be appetizing. During a resident council meeting on 1/07/26 at 11:00 a.m. in dining hall, 3 residents who resided in Hall 4 (Resident 90, Resident 7 &amp; Resident 53) complained that the food was always cold because they were served last.</p> <p>A review of the resident council notes indicated that cold food was reported in 08/25, again in 11/25, and in 12/25.</p> <p>During a tray line observation in the kitchen on 1/07/26 at 12:05 p.m., the cook began to plate the food for the residents' lunch.</p> <p>Continuing the tray line observation on 1/07/26 at 1:14 p.m., staff began to pass lunch trays to the residents residing on Hall 4.</p> <p>During a test tray observation and concurrent interview on 1/07/26 at 1:19 p.m., the survey team tested a tray of pureed fish, potatoes, carrots, and bread and a tray of regular texture fish, tater tots, carrots and a roll with Registered Dietitian (RD). RD took the temperatures of the pureed foods as follows: Carrots 100 degrees , potatoes 110 degrees , fish 110 degrees . Upon tasting the pureed food, the survey team agreed the temperature of the carrots was too cold. RD then took the temperatures of the regular texture foods as follows: Tater tots 105 degrees , carrots 105 degrees , fish 100 degrees . Upon tasting the regular texture food, the survey team agreed all the foods were too cold. RD sampled the food on the regular texture tray and agreed the food was cooler than it should be. RD stated, It could be warmer.</p> <p>During a phone interview on 1/08/26 at 8:56 a.m., RD stated she usually would hear people say the food was cold with the last hall (Hall 4). RD stated she thought the food was cool on the test tray because it was a longer tray line because it was fish day and the residents' increased demand for alternatives.</p> <p>Review of facility policy titled, Food and Nutrition Services Staff, last revised on 10/2017, indicated, Food will be palatable, attractive, and served in a timely manner at proper temperatures.</p> |                                                                                      |                                                 |



|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                 |
| <p>F 0812</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to safely store residents' food when the two refrigerators used to store residents' personal food from outside the facility were not monitored for proper labeling or outdated items. This failure had the potential to cause food-borne illnesses. During an observation and concurrent interview on 1/06/26 at 2:20 p.m., Licensed Nurse (LN) B stated there was a refrigerator at each nurses' station that was for residents' foods brought in from outside the facility. The refrigerator for residents' foods at Nurses' Station 2 contained several items that were not labeled or were outdated. LN B stated Housekeeping Supervisor (HKS) was responsible for monitoring the foods in the refrigerators and throwing away foods when they needed to be thrown out. LN B stated whoever put items in the refrigerator was responsible for labeling the item, and the label needed to include the resident's name, room number, and the date and time it was put in there. During an observation and concurrent interview on 1/06/26 at 2:27 p.m., HKS verified she was responsible for monitoring food in the refrigerators for residents' foods at the nurses' stations. HKS stated that twice a week she checked the foods in the refrigerators to make sure it was properly labeled. HKS stated if the food had been in there for more than three days, she would let the resident know that it needed to be eaten or tossed. HKS stated that the residents could potentially get moldy food or it could go bad if the food was not properly monitored. From the Station 2 refrigerator, HKS removed two plastic containers of food (one with a sandwich, one with a few sausages) not labeled, a paper grocery bag containing a gallon of milk with a use by date of 12/1/25 and a container of sour cream with a delivery date of 11/16/25, a frozen ice cream milkshake with no date or name, a box of vegetable spring rolls with no name or date, two half-gallons of ice cream with no name or date, several ice cream sandwiches all with no name or date, and a pina colada-flavored fruit drink with a use by date of 12/2025 and no name or date. HKS stated all the removed items needed to be thrown away. HKS verified the use-by date on the milk of 12/1/25 and stated that since it was a whole gallon of milk she would ask the resident before she threw it away. During an observation and concurrent interview on 1/06/26 at 2:35 p.m., the refrigerator for residents' food at Station 1 contained a tub of whipped topping and a container of take-out food, both with no name or date. The freezer contained various frozen treats and had a black and white cloth ice pack with a name written on it in black marker. Licensed Nurse (LN) C stated the black and white cloth item in the freezer was a cold pack for pain relief. LN C stated she did not know the resident whose name was on the ice pack. LN C asked another nurse at the nurses' station, but she did not recognize the name on the ice pack either. LN C stated the ice pack should not be in the freezer with food. During a phone interview on 1/08/25 at 8:56 a.m., Registered Dietitian (RD) stated nursing had their own checklist of tasks and they checked the refrigerators at the nurses' stations for dates on the residents' foods. RD stated she checked periodically herself and has not seen any out-dates. RD stated it had come up in resident council that residents were upset that their food gets tossed, but we need to be throwing away expired food. When queried regarding outdated food, RD stated, depending on the type of food, the risk to residents was possible food-borne illness. RD stated she was unaware of the ice pack, but it should not be in the freezer meant for food due to the risk of cross-contamination with bio-hazard. During an interview on 1/08/25 at 11 a.m., Assistant Director of Nursing (ADON) stated the housekeeping supervisor or the nurses were responsible for monitoring the food in the refrigerators at the nurses' stations. ADON stated if there were concerns about the foods in the refrigerators, HKS was who she would go to first. When queried about the milk that was five weeks past the use-by date, ADON stated she would dump the milk and tell the resident. ADON stated, We have milk in the kitchen. ADON stated that she felt it made sense that the nurses should be in charge of monitoring the residents' personal food in the refrigerators at the nurses' stations. ADON stated no ice packs for pain should be in those refrigerators due to infection control. Review of facility policy Foods Brought by (continued on next page)</p> |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | Family/Visitors, last revised 3/2022, indicated, . Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the 'use by' date. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                                                 |
| F 0583<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview, and record review, the facility failed to protect residents' private health information when lunch tray tickets containing residents' names and diet orders were found thrown in the garbage in the dining room. This failure had the potential for residents' private health information to be obtained by persons who did not have a need to know the residents' information. During an observation on 1/05/26 at 12:46 p.m. in the RNA (Name of dining hall) Dining Hall, resident tray tickets were observed in the trash can. During an interview on 1/08/26 at 2:45 p.m., the Assistant Director of Nursing (ADON) stated that no tray tickets should be in the trash as they contain protected health information. A review of the facility policy titled, Confidentiality of Information and Personal Privacy, revised 10/25, indicated, the facility would safeguard the personal privacy and confidentiality of all resident personal and medical records. |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                                                 |
| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide the required documentation or notification related to the resident's needs, appeal rights, or<br>bed-hold policies.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on<br>interview and record review, the facility failed to notify the ombudsman's office (a public agency that<br>provides free advocacy services for residents of nursing homes) of a transfer to the hospital for one<br>of three residents sampled for closed record review (Resident 98). This failure had the potential to<br>result in a lack of advocacy services for Resident 98. During a record review on [DATE] at 9:49 a.m.,<br>Resident 98's face sheet indicated Resident 98 was admitted to the facility on [DATE] with multiple<br>diagnoses including but not limited to heart failure (condition where the heart can't pump enough<br>blood and oxygen to meet the body's needs), coronary artery disease (cholesterol build-up on the<br>inside of the vessels that bring blood to the heart muscle), end-stage kidney disease (the kidneys can<br>no longer function adequately, requiring dialysis or a kidney transplant for survival), diabetes mellitus<br>(impaired ability to metabolize blood sugar), and an implanted defibrillator (a device implanted in the<br>chest that delivers electrical shocks or pacing to correct life-threatening, abnormal heart rhythms).<br>Review of Resident 98's nurse progress note dated [DATE] at 12 p.m. revealed Resident 98 was sent<br>to the local hospital emergency room when he was abnormally drowsy and had swelling to his left<br>chest. During a record review on [DATE] at 10:08 a.m., Resident 98's hospital records indicated that<br>Resident 98 had been sent to another nearby hospital for a higher level of care and died in the<br>intensive care unit on [DATE]. During an interview on [DATE] at 12:35 p.m., Administrator verified<br>she had been unable to find documentation the ombudsman's office had been notified of Resident 98's<br>transfer to the hospital. Review of facility policy Transfer or Discharge Notice, last revised 10/2025,<br>indicated, Our facility shall provide a resident and/or the resident's representative with notice of an<br>impending transfer or discharge. A copy of the notice will be sent to the Office of the State<br>Long-Term Care Ombudsman. |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                 |
| <p>F 0644</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASRR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) program for one of six sampled residents when Resident 5's Level I PASSR did not accurately reflect a serious mental disorder, and Resident 5 was not referred for a Level II PASRR (a level II PASRR screening determines appropriate placement of an individual with a serious mental illness, considering the least restrictive setting, and whether specialized services are needed) screening. This failure had the potential for Resident 5 to receive inappropriate or ineffective care, treatment, and services. During a review of Resident 5's admission Record, it indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including paraplegia (the loss of muscle function in the lower part of the body including both legs), generalized muscle weakness, acute kidney failure, and schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (like hallucinations or delusions) with a mood disorder (depression or mania)). During a review of Resident 5's, Minimum Data Set (MDS, an assessment tool), dated 11/26/25, the MDS indicated the resident's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) indicated moderate cognitive impairment. The MDS also indicated Resident 5 had an active diagnosis of schizophrenia. During a review of Resident 5's, Order Summary Report, dated 1/07/26, it indicated Resident 5 was receiving Seroquel (an oral prescription medication that balances natural substances in the brain to improve mood, thoughts, and behavior) once a day at bedtime for, schizophrenia M/B [manifested by] auditory hallucinations. During a review of the Department of Health Care Services (DHCS), Preadmission Screening and Resident Review (PASRR) Level 1 Screening for Resident 5, dated 11/18/25, the PASRR Level 1 evaluation questions indicated Resident 5 did not have a diagnosed or suspected mental illness. This document also indicated Resident 5 was not receiving any psychotropic (psychiatric) medications. During a review of DHCS correspondence with the subject, Notice of PASRR Level 1 Screening Results, dated 11/18/25, it indicated Resident 5 did not require a level II Mental Illness Evaluation Referral due to, Negative for SMI (severe mental illness). During an interview on 1/08/25 at 1:25 p.m., the Assistant Director of Nursing (ADON) stated that the nursing department was responsible for ensuring the PASRR was correctly filled out and initiated a new evaluation if there was a change in condition. The ADON also stated it was important this process was completed correctly so that residents were appropriately placed in the best setting for their needs, and to protect current residents in the facility. A review of the undated facility policy and procedure titled, Pre-admission Screening and Resident Review (PASRR), indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), and related disorders (RD). If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASRR representative for the Level II (evaluation and determination) screening process. Upon completion of the Level II evaluation, the State PASRR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.</p> |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                      |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to initiate and implement a resident-centered nursing care plan for depression for one of six sampled residents (Resident 32). This failure had the potential to worsen or delay improvement of Resident 32's diagnosed psychiatric condition. A review of Resident 32's admission Record, indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (one-sided muscle weakness), and major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and significant impairment in daily life). A review of Resident 32's Minimum Data Set (MDS, an assessment tool), dated 12/07/25, indicated Resident 32 had a BIMS (Brief Interview for Mental Status-an assessment used in long-term care facilities to quickly screen for cognitive impairment) of 12, indicating moderate cognitive impairment. The MDS also indicated in the past two weeks Resident 32 had little or no interest or pleasure in doing things nearly every day and had an active diagnosis of depression. A record review of Resident 32's physician progress notes dated 11/06/25, indicated Resident 32 was assessed with depression. During an interview on 1/05/26 at 1:55 p.m. with Resident 32 in her bedroom, Resident 32 would not speak, and answered simple questions by shaking her head up and down or side to side only. During an interview on 1/08/26 at 2:31 p.m. the Assistant Director of Nursing (ADON) stated there should have been a nursing care plan in place for Resident 32's depression diagnosis to monitor disease progression, and to set goals and interventions for management of the condition, but there was none. A review of the facility's undated policy and procedure (P & P) titled, Care Planning, indicated, A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). |                                                                                      |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowood Nursing Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3805 Dexter Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                 |
| <p>F 0676</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 73), received services to maintain functional abilities when staff did not transfer him out of bed and into his wheelchair for an undetermined length of time. This failure had the potential to decrease Resident 73's functional mobility, which could have resulted in skin breakdown, and increased dependency on staff for Activities of Daily Living (ADL's, activities related to self-care such as bathing and toileting). A review of Resident 73's admission record indicated he was admitted on 12/2022 with medical diagnoses which included Rheumatoid Arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle wasting and atrophy (loss or thinning of muscle tissue), and abnormalities of gait and mobility. A review of Resident 73's Minimum Data Set (MDS-a resident assessment tool) dated 12/24/25, indicated he had a BIMS (Brief interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of resident) score of 11, which indicated his cognition was moderately impaired. The MDS further indicated Resident 73 required a wheelchair for mobility and was completely dependent for bed to chair transfers. A review of a physicians progress note, dated 11/9/25, indicated Resident 73 could not walk and had severe bilateral lower extremity muscle atrophy. A review of an occupational therapy progress note for Resident 73, for the certification period of 9/15/25 through 11/09/25, indicated that due to documented physical impairments and functional deficits without skilled intervention, the resident was at risk for decreased level of mobility, decreased leisure task participation, decreased participation in functional tasks, further decline in function, falls, increased dependency upon caregivers, limited out-of-bed activity, and muscle atrophy. A review of Resident 73's nursing care plan, revised on 8/01/25, indicated Resident 73 had contractures, limited mobility, and required assistance from two staff with a Hoyer Lift (A mechanical appliance to transfer the resident from and to bed) and a wheelchair with non-skid and pressure-relieving surface for mobility. During an interview on 1/05/26 at 2:30 p.m., with Resident 73 in his room, he stated the facility had misplaced his wheelchair and he had not been up in a wheelchair or taken outside in five months and that nobody had followed up with him about it. During a concurrent observation and interview on 1/07/26 at 3:45 p.m., Licensed Nurse D (LN D) stated he did not know what happened to Resident 73's wheelchair and confirmed that there was no wheelchair for use in Resident 73's room. During an interview on 1/08/26 at 8:44 a.m. Certified Nursing Assistant A (CNA A) stated she remembered that Resident 73's wheelchair went missing and she talked to occupational therapy about it. CNA A further stated Resident 73 needed a comfortable wheelchair to be up due to contractures in his legs and had not been out of bed in a long time. During an interview on 1/08/26 at 2:45 p.m. the Assistant Director of Nursing (ADON) stated she would have expected to hear about a missing wheelchair and would expect staff to do something about it, not to just leave the resident in bed, as this could lead to further mobility issues and skin breakdown and would cause the resident to feel upset. A review of a facility policy titled, Activities of Daily Living (ADL's), Supporting, revised on 10/25, indicated, Residents will be provided care, treatment, and services appropriate to enable them to carry out activities of daily living. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of resident and in accordance with the plan of care, including appropriate support and assistance with: . Mobility ( including but not limited to transferring in and out of bed, ambulation, and walking).</p> |                                                                                      |                                                 |