STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555713	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowood A Health and Rehabilitation Center	3110 Wagner Heights Road Stockton, CA 95209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure that one of three sampled resident's (Resident 3) call lights was functioning properly when Resident 3's call light did not light up outside his bedroom doorway when the call light button was pressed.This failure resulted in Resident 3 experiencing an episode incontinence and put Resident 3 at risk of fall or injury.A review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility in 2025, with diagnoses which included Pneumonia (a lung infection) and lack of coordination.During an interview on 8/14/25, at 10:09 AM, with Family Member (FM)1, FM 1 stated Resident 3's call light was not working from Saturday 8/2/25 through Tuesday 8/5/25. FM 1 further stated Resident 3 pressed his call light but the light above the door did not light up. FM 1 stated there was an incident where Resident 3 was incontinent (not able to hold urine) of urine and no one responded to his call light for assistance to the bathroom. FM 1 stated Resident 3 was unable to get up to go to the bathroom.A review of Resident 3's clinical document titled, Care Plan, dated 7/24/25, indicated, .Problem. Potential for falls and injury due to unsteady gait.Approach.CALL LIGHT WITHIN REACH AND ANSWERED PROMPTLY.ENSURE RESIDENT UNDERSTANDS HOW TO USE CALL LIGHT.During an interview on 8/14/25, at 1:08 PM, with Certified Nurse Assistant (CNA) 1, CNA 1 stated when a call light was broken the staff wrote an entry in the maintenance log. CNA 1 further stated if the call light broke on a weekend, maintenance waited until Monday to fix it. CNA 1 stated she was unaware of other options for the residents when the call light was not working. During a telephone interview on 8/15/25, at 10:28 AM, with Licensed Nurse (LN) 3, LN 3 stated when a call light was not working, she would check with maintenance. LN 3 further stated she was not sure if the facility had spare call lights or hand bells to provide for the residents when the call lights did not work.A review of a facility document titled, Maintenance Log, indicated, .8/2.Item Location. [Resident 3's room]. Call Light Broken.8-4.Fixed. and .8/5.Item Location. [Resident 3's room].Call Light Broke. 8-5.Fixed .During an interview on 8/14/25, at 2:24 PM, with the Administrator (ADM), the ADM confirmed the call light had not been illuminating outside Resident 3's doorway. The ADM stated when Resident 3 pressed his call light, the panel by the nurse's station lit up. The ADM further stated Resident 3 was not provided a hand bell because the light was working at the panel even though it was not working outside Resident 3's room. During a telephone interview on 8/15/25, at 1:15 PM, with the Director of Maintenance (DOM), the DOM confirmed the call light outside room Resident 3's room had been broken. The DOM stated that the light would only show up at the panel near the nurse's station and not outside Resident 3's room. The DOM further stated when a call light was broken the staff placed an order in the electronic maintenance request system. The DOM stated the maintenance department received a work order for Resident 3's call light on 8/3/25 and the light bulb was replaced on 8/4/25. The DOM stated the wrong bulb was used on 8/4/25 and it overheated and popped. The DOM further stated the correct bulb was placed on 8/5/25.A review of a facility policy titled, Call Light System, dated 3/5/02, indicated, .Each resident will be provided the means to communicate their immediate needs with the staff and provide the staff with a means to identify residents with immediate needs.Procedure.When resident activates call light, the light above resident's door will light as well as the corresponding light at the nurse's station. A staff member will respond promptly, and attend to resident's immediate need.If the call light system malfunctions, an alternative method such as individual bells will be initiated until the call light system is functioning again.