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	05/21/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect one of three sampled resident's (Resident 2's) right to be free from neglect (failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress) when, Certified Nursing Assistant (CNA) 2 placed tape over the reset button on the call light panel in Resident 2's room, which prevented the call light from working on 3/11/26.This failure had the potential to decrease Resident 2's safety and psychosocial well-being.Findings:A review of Resident 2's admission Record, indicated that Resident 2 was admitted to the facility in 2026 with diagnoses which included dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Urinary Tract Infection (UTI, a condition in which germs invade and grow in the urinary tract), difficulty in walking, and legal blindness (severe vision loss).A review of Resident 2's Minimum Data Set (MDS; and assessment tool), dated 3/5/26 indicated, Resident 2's Brief Interview for Mental Status (BIMS; used to evaluate a resident's memory, orientation, and ability to process information) score was a 10 (scoring ranges from 00 to 15, with a score of 10 indicating moderately impaired cognition). Resident 2's Section GG [evaluates a resident's functional abilities and goals in self-care and mobility] of the MDS indicated, Resident 2 used a wheelchair, with a need for substantial assistance (helper provides more than half the effort) for toileting/hygiene/shower/bathing/lower body dressing/footwear, partial assistance (helper provides less than half the effort) with upper body dressing/eating, substantial assistance with sit to stand/chair to bed transfer/toilet transfer, partial assistance with walking, and substantial assistance with the use of the wheelchair.A review of Resident 2's impaired vision care plan, start date 3/11/26, in the section titled Problem, indicated, .Resident has severely impaired vision R/T [related to] blindness to both eyes. In the section titled Approach, indicated, .Keep call light in reach at all times.Remind resident to call and wait for help with all transfers.A review of Resident 2's fall risk care plan, start date 3/1/26, in the section titled Problems, indicated, POTENTIAL FOR FALLS AND INJURY DUE TO: unsteady gait and weakness, BLINDNESS,HX [history (sic)] OF FALLS. In the section titled Approach, indicated, .Approach Start Date: 03/01/2026.ASSIST WITH TOILETING NEEDS.Approach Start Date: 03/01/2026.CALL LIGHT WITHIN REACH AND ANSWERED PROMPTLY. Approach Start Date: 03/01/2026.ENSURE RESIDENT UNDERSTANDS HOW TO USE CALL LIGHT. DEMONSTRATE USE AND HAVE RESIDENT COMPELTE RETURN DEMONSTRATION.A review of Resident 2's Activities of Daily Living (ADL's) care plan, start date 3/1/26, in the section titled Problem, indicated, .ADLs Functional Status/Rehabilitation Potential SELF CARE DEFCIT MANIFESTED BY IMPAIRED: BED MOBILITY, TRANSFER [movement from one surface to another], LOCOMOTION [moving from one place to another], DRESSING, EATING, TOILET USE, PERSONAL HYGEINE, BATHING.A review of Resident 2's Progress Notes, indicated, .03/11/2026 20:07.MAINTENANCE LEAD WAS GOING TO RESIDENT ROOM THINKING HE WAS GOING TO FIX A CALL LIGHT MALFUNCTION. WHEN ENTERING THE RESIDENT ROOM, MAINTENANCE LEAD NOTICED THAT IT WAS NOT A MALFUNCTION AND THAT THERE WAS TAPE ONTOP [sp] OF THE CALL LIGHT HOLDING IT DOWN SO THAT IT WAS NOT FUNCTIONAL FOR THE PATIENT [Resident (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

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	05/21/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2] TO CALL FOR ASSISTANCE. MAINTENANCE LEAD IMMEDIATELY NOTIFIED ADMINISTRATOR. ADMINISTRATOR NOTIFIED DON [Director of Nursing] WHOM [sp] NOTIFIED MD [Medical Doctor], RP [Responsible Party, the person designated to direct the care of a loved one admitted into a nursing facility] AND.PD [Police Department]. STAFF MEMBER WAS TAKEN OFF THE FLOOR FOR FURTHER INVESTIGATION. AT THIS TIME, CONSTANT ROOM CHECKS MADE TO THE RESIDENT. CALL LIGHT IS FUNCTIONAL AND WITHIN REACH. ALL NEEDS MET BY STAFF.During an interview with Resident 2 in his room on 5/20/26 at 12:10 p.m., Resident 2 was well-groomed and well-dressed, lying on his bed with the call light within reach. Resident 2 stated that he felt safe at the facility. Resident 2 stated that the staff treated him with dignity and respect. Resident 2 stated that he did not remember when the call light was not working so that he could not use it. Resident 2 stated that the staff responded when he called for help.During an interview with the Maintenance Lead (ML) on 5/20/26 at 1:43 p.m., the ML stated that he saw Resident 2 earlier that day and spoke with him. The ML stated that he told Resident 2 that he would stop by his room to check on him later that day. The ML stated that on the date of the incident, he walked into Resident 2's room and Resident 2 was actively pressing his call light. The ML stated that Resident 2 stated to him that he did not think that his call light was working. The ML stated that Resident 2 was in his bed lying on his back and repeatedly pressing the call light. The ML stated that he looked at the panel for the call light above Resident 2's bed and saw that the reset button for the call light was taped. The ML stated that he told Resident 2 that he would be right back and walked toward the room door to go find a nurse. The ML stated that when he walked out of the door, Certified Nursing Assistant (CNA) 2 came into the room and he followed CNA 2 back into the room, pointed at the call light reset button and said to CNA 2, You can't do that! The ML stated that CNA 2 answered, What? went to the reset panel for the call light and began to pull the tape off the reset button, so he took a picture with his cell phone and went to the Administrator (ADM) to report the incident. The ML stated that Resident 2 was blind and could not see that the light was not on at the call light panel in his room or that the reset button had been taped.During an interview by phone with CNA 2 on 5/21/26 at 10:31 a.m., CNA 2 confirmed that she was assigned to care for Resident 2 on the day of the incident. CNA 2 stated that after she finished assisting Resident 2 with his lunch that day, she told Resident 2 that she was going to assist the resident across the hall back to bed. CNA 2 stated that when she returned to Resident 2's room, she assisted Resident 2 back to bed. CNA 2 stated that on the day of the incident Resident 2 had pressed his call light frequently. CNA 2 stated that she was standing in the doorway when the ML went into Resident 2's room. CNA 2 stated that after the ML went into Resident 2's room, she went into Resident 2's room, and Resident 2 told the ML that his call light was not working. CNA 2 stated that she did not see the tape on the reset button until the ML pointed it out to her. CNA 2 stated that the ML was mad and asked her if she put the tape on the reset button, and CNA 2 stated that she told the ML that she did not do it. CNA 2 stated that when she began to remove the tape, the ML took a picture of the reset button on the call light panel in Resident 2's room with his cellphone and went to the ADM's office. CNA 2 denied putting tape on the reset button on the call light panel in Resident 2's room and stated that she did not know who put the tape on the reset button in Resident 2's room. CNA 2 stated that she went to the nurses' station and told the charge nurse that the reset button in Resident 2's room was taped but that she did not know who did it. CNA 2 stated that the ADM called her to the office later and told her that she had to go home because they had to investigate the incident. CNA 2 stated that the ADM called a few days later and told her that she was terminated. CNA 2 stated that she did not do anything wrong.During an interview with Licensed Nurse (LN) 1 on 5/21/26 at 11:42 a.m., LN 1 stated that she knew Resident 2. LN 1 stated that Resident 2 was on the other unit when the taped call light reset button incident occurred and was moved to his current room after the incident. LN 1 stated that if she walked into a room where the call light reset button was taped, she would ask the resident if he or she were okay, report it to the ADM, and start an abuse report form.During an interview with CNA 1 on 5/21/26 at 11:50 a.m., CNA 1 stated that the tape (continued on next page)

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	05/21/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not be on the call light reset button. CNA 1 stated that putting tape on the call light reset button was a form of neglect.During an interview with LN 2 on 5/21/26 at 11:54 a.m., LN 2 stated that if she entered a resident's room and the call light reset button was taped, she would call to report it to the ADM and file the abuse form because it would be considered abuse. During an interview with the Director of Nursing (DON) on 5/21/26 at 12:58 p.m., the DON stated that her expectation was that staff, including the CNA's and LN's, answer the residents' call lights as soon as possible. The DON stated that the risk of not answering the residents' call lights timely was that the resident could be in pain and need pain medication, the resident could need to go to the bathroom or could be incontinent (involuntary loss of urine of feces). The DON stated that the residents used their call lights as a way of communicating their needs with the staff. The DON stated that she was aware of the incident involving Resident 2's call light reset button being taped so that Resident 2's call light was not working. The DON stated that since the call light was not functioning due to the tape, Resident 2 could not use it to call for assistance, and that was a form of abuse. The DON stated the facility suspended CNA 2 who was caring for Resident 2 on the day of the incident, the facility investigated the incident, and the facility later fired CNA 2.During an interview with the ADM and the DON on 5/21/26 at 3 p.m., the ADM stated that immediately after the incident of the taped call light was reported, an investigation into the incident was started. The ADM stated that CNA 2, who was caring for Resident 2 at the time of the incident was immediately suspended and left the premises for Resident 2's safety. The ADM stated that CNA 2 admitted that she taped the reset button on the call light panel in Resident 2's room and had left the resident unattended for about five minutes. The ADM stated that CNA 2 was terminated.A review of a facility policy and procedure (P&P) titled, Elder and Dependent Adult Suspected Abuse & Reporting, revised 11/21, the P&P indicated, .Policy Statement.Residents have the right to be free from abuse, neglect.Mandated reporters shall report any such incidents by staff, visitors, or residents.Policy Interpretation and Implementation.Neglect.Failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.A review of a facility document titled, Code of Conduct, revised 12/16, the Code of Conduct, indicated, .Resident Rights.Skilled Nursing.Residents receiving healthcare and other services have clearly defined rights. To honor these, we must.Protect every resident from.neglect.Abuse and Neglect.We will not tolerate any type of resident abuse or neglect.This standard applies to all residents at all times.Abuse and neglect must be reported immediately.in accord [sp] with the mandatory reporting requirements.A review of an undated facility document titled, Certified Nurse Assistant CNA, the document indicated, .Position Summary.the CNA job entails all facets of resident care and support including but not limited to daily life enrichment tasks such as providing direct personal care.Essential Functions.2. Provide ongoing routine checks and ongoing night checks including timely response and answering pull cord (call light) .16. Ensures the safety, health and welfare of. residents at all times.19. Adheres to company policies and.Code of Conduct.