| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555713 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/28/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Meadowood A Health and Rehabilitation Center | 3110 Wagner Heights Road Stockton, CA 95209 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>47369<br><br>Based on observation, interview, and record review, the facility failed to ensure residents rights to be treated with dignity and respect were honored for one of twenty two sampled residents (Resident 38) when Resident 38's meal was placed in front of her, but not fed to her, for greater than 20 minutes.<br><br>Findings:<br><br>A review of Resident 38's Resident Face Sheet, indicated she was admitted to the facility with diagnoses which included Alzheimer's disease (a progressive disease that affects the parts of the brain that control thought, memory, and language).<br><br>A review of Resident 38's Care Plan History, dated 8/1/19, indicated, Problem .Nutritional Status . AT RISK FOR ALTERED NUTRITIONAL STATUS . Requires assistance with feeding .<br><br>During an observation in the memory care unit (focuses on the care and well-being of individuals with memory issues) dining room, on 2/25/25, at 12:15 PM, Resident 38 was observed seated at a table with a plate of food in front of her. Resident 38 was alert and looking around the room. Licensed staff were observed feeding another resident seated at the table with Resident 38.<br><br>During an observation on 2/25/25, at 12:31 PM, Resident 38 was observed crying out (to shout or make a loud noise), her plate of food remained in front of her. Licensed staff continued to feed the other resident at the table.<br><br>During an observation on 2/25/25, at 12:38 PM, Licensed Nurse (LN) 6 began to feed Resident 38 her meal. The temperature of the potatoes on Resident 38's plate registered 110 degrees Fahrenheit (F ) when LN 6 began feeding her.<br><br>During an interview on 2/25/25, at 1:38 PM, LN 6 stated she had placed Resident 38's tray in front of her on the table because she thought a Certified Nurse Assistant (CNA) student would be coming to feed the residents. LN 6 further stated when no one came LN 6 started feeding the other resident seated at the table. LN 6 stated Resident 38 may have been wondering why she was not eating too. LN 6 stated it created a dignity issue for Resident 38 when she had to sit and watch the other resident eat.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/26/25, at 1:24 PM, the Director of Nurses (DON) stated it was her expectation that all residents at a table would eat their meals at the same time. The DON further stated it was a dignity issue to not serve residents their meals together. The DON further stated when Resident 38's meal was delayed staff should have informed the kitchen and received a fresh meal tray.<br><br>During an interview on 2/27/25, at 12:45 PM, the Certified Dietary Manager (CDM) stated food served to residents should be between 145-150 F . The CDM further stated that it was inappropriate to serve food that was 110 F . The CDM stated staff should have requested a new tray or fed Resident 38 when her tray had arrived.<br><br>A review of an undated, facility provided document titled, Know Your Rights under Federal Nursing Home Regulations, indicated, . you have the right to be treated with respect and dignity .<br><br>A review of a facility policy titled, Supervision of Resident Nutrition, dated 5/1997, indicated, .Each resident shall receive proper nutrition .Residents needing assistance in eating must be promptly assisted upon being served .<br><br>A review of a facility policy titled, Meal Temperature, dated 1/1/21, indicated, .All food items are evaluated for proper food temperature, taste, and appearance prior to meal service .Food and drinks should be palatable, attractive and served at a safe and appetizing temperature .to ensure patients/residents' satisfaction .Do not serve food at unacceptable temperatures . |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>50925<br><br>Based on interview, and record review, the facility failed to ensure one of twenty two sampled residents (Resident 64) had their rights related to treatment choices known and protected when a copy of Resident 64's Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) was not kept in Resident 64's record.<br><br>This failure had the potential to result in Resident 64's preferences for emergent and end of life treatment to not be followed.<br><br>Findings:<br><br>A review of Resident 64's medical record titled, Resident Face Sheet, indicated that Resident 64 was admitted to the facility in early 2024 with diagnoses that included aftercare following right hip joint surgery, fracture of neck of right femur (upper part of the thigh), and need for assistance with personal care.<br><br>A review of Resident 64's medical record titled, Physician Orders for Life-Sustaining Treatment [POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life], dated 1/14/24, indicated Section D that an Advance Directive was discussed with the Resident 64 and that Resident 64 had an Advance Directive.<br><br>A review of Resident 64's physical chart (paper medical record) at the nurses station, indicated that a copy of Resident 64's POLST was in the chart but no copy of an Advance Directive was found.<br><br>A review of Resident 64's Electronic Health Record (EHR - information stored in the facility's computer system), indicated that Resident 64's Advance Directive was not uploaded into Resident 64's EHR.<br><br>During a concurrent interview and record review with the Social Services Director (SSD), on 2/26/25, at 2:34 p.m., the SSD confirmed that there was no copy of an Advance Directive found in Resident 64's EHR. The SSD stated that the Advance Directive copy should have been scanned into Resident 64's EHR. The SSD also confirmed that there was not an Advance Directive copy found in Resident 64's physical chart at the nurses station. The SSD stated that the admitting nurse should have reviewed the POLST information during the admission process and should have ensured that a copy of Resident 64's Advance Directive was obtained if the resident had an Advance Directive. The SSD stated that the importance of having the Advance Directive copy was for the resident's wishes to be known and to determine who would be in charge or appointed if they would not be able to make their own decisions. The SSD added that the POLST and Advance Directive copies should be in the resident's chart because these copies would be taken with the resident if they were transferred out to another facility.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review with the Director of Nursing (DON), on 2/27/25, at 12:47 p.m. , the DON confirmed that Resident 64's copy of the Advance Directive was not found in Resident 64's EHR. The DON stated that the copy should be in Resident 64's chart since the POLST form specified that there was an Advance Directive. The DON stated that it was her expectation for the Advance Directive copy to have been in Resident 64's chart at all times. The DON stated that the process involved the admission nurse initiating the POLST form with the resident, responsible party, or family, during the admission process. The DON stated that it was her expectation to get the POLST form completed as soon as possible. The DON further stated that the facility conducts a 72-hour conference after admission with the admitting nurse, Social Services and Admissions Coordinator and they should have reviewed these forms to ensure that they were completed. The DON stated that the importance of having the Advance Directive in the chart was to provide legal guidance when providing care. The DON added that the POLST and Advance Directive forms would go with the resident whenever they were sent or transferred out of the facility.<br><br>A review of the facility's document titled, Physician Orders for Life-Sustaining Treatment [POLST], dated 10/6/09, indicated .Completing a POLST form with the resident: 1. If the resident or representative chooses to complete a POLST form .Discussion will include the resident's Advance Directive (if done) or other statements the resident has made regarding their wishes for end of life care and treatments .<br><br>A review of the facility's document titled, Advance Directives, dated 8/13/08, indicated .1. On admission, each resident is asked if they have completed an Advance Health Care Directive .a. If a Directive has been completed, the community shall request a copy to be included in the medical record .3. At least quarterly, the completed Advance Health Care Directive will be reviewed with the resident and their responsible party, as applicable . |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>47369<br><br>Based on observation, interview, and record review, the facility failed to ensure residents rights of privacy and confidentiality were honored for one of twenty two sampled residents (Resident 12) when Resident 12's incontinence (lacking control of bowel and bladder) care needs were posted in public view in his room.<br><br>Findings:<br><br>A review of Resident 12's Resident Face Sheet, indicated, he was admitted to the facility with diagnoses which included urinary incontinence (inability to control urination/bladder).<br><br>During an observation in Resident 12's bedroom on 2/26/25, at 9:46 AM, a handwritten sign and two photos were observed posted on Resident 12's bathroom door facing out into the room. The sign indicated, . [Resident 12's] Cath Bag [urine collection bag] .AM .Remove old condom tip [condom catheter used to direct urine to a collection bag] with Adhesive remover wipe .Use NoSting Prep [skin protectant] to place new condom tip .attach leg bag to top of calf and above ankle .PM .Remove old condom tip with Adhesive remover wipe/spray .attach to 2000ml [milliliter] bag . The photos included pictures of the condom catheter packages, the wipes, and the drainage bags to attach to the catheters.<br><br>During a concurrent interview and document review (sign and photos) in Resident 12's room, on 2/26/25, at 10:24 AM, licensed nurse (LN) 6 stated the information for Resident 12's condom catheter was posted on the bathroom door to inform staff of which supplies to use. LN 6 further stated, for privacy, the documents could have been posted inside the bathroom door.<br><br>During a concurrent interview and document review (sign and photos) in Resident 12's room, on 2/26/25, at 1:28 PM, the Director of Nurses (DON) stated any sign posted in a resident's room with personal information should be covered with a blank page. The DON further stated not covering the postings created a dignity issue for Resident 12.<br><br>A review of an undated, facility provided document titled, Know Your Rights under Federal Nursing Home Regulations, indicated, .you have the right to be treated with respect and dignity . |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>47369<br><br>Based on observation, interview, and record review, the facility failed to ensure one of twenty two sampled residents (Resident 12) was free from physical restraint when Resident 12 was unable to independently unbuckle the self-release belt he wore while seated in his wheelchair.<br><br>This failure had the potential for Resident 12 to experience a lack in freedom of movement, injury, and psychosocial distress.<br><br>Findings:<br><br>A review of Resident 12's Resident Face Sheet, indicated he was admitted to the facility with diagnoses which included Parkinsonism (a progressive disease of the nervous system marked by tremor, muscle rigidity, and slow imprecise movement) and unspecified dementia (condition that causes a decline in memory, thinking, reasoning, and problem solving).<br><br>A review of Resident 12's Minimum Data Set (MDS, federally mandated resident assessment and screening tool) Section C - Cognitive Patterns, dated 1/4/25, indicated Resident 12's Brief Interview for Mental Status (BIMS, cognitive screening test, a score of 0-7 suggests a severe cognitive impairment, 8-12 suggests moderate cognitive impairment, 13-15 suggests intact cognitive response) score was 7.<br><br>A review of Resident 12's MDS Section GG-Functional Abilities, dated 1/4/25, indicated Resident 12 required, .Partial moderate assistance-Helper does LESS THAN HALF the effort . for the categories of eating and upper body dressing.<br><br>A review of Resident 12's Restraint/Adaptive Equipment Use Assessment, dated, 11/13/24, indicated, . resident requested a self release belt for when he's up in chair md (medical doctor) notified md approved observation complete. patient educated on how to use the belt and patient demonstrated how to release belt on his own .<br><br>A review of Resident 12's Care Plan History, dated 11/13/24, indicated, .Problem .Self release belt when up in wheelchair related to involuntary movement related to his disease process .Approach .resident is able to self release belt .<br><br>During an observation on 2/26/25, at 10:15 AM, Resident 12 was observed in his room seated in his wheelchair. When asked to demonstrate how his self-release belt was unbuckled, Resident 12 reached down to his belt, grasped the sides of the buckle and wiggled it up and down, he tried to pull on the buckle and stated, I can't.<br><br>During a concurrent observation and interview on 2/26/25, at 10:25 AM, Licensed Nurse (LN) 6, stated Resident 12 could remove his belt independently. LN 6 prompted Resident 12 to open the belt buckle, Resident 12 tried but was unable. LN 6 prompted him a few more times and then opened the buckle for him. LN 6 confirmed Resident 12 was unable to release the belt buckle independently.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 2/26/25, at 2:01 PM, the MDS Coordinator (MDSC) stated Resident 12 had Parkinson's disease which affected his cognition and mobility. The MDSC stated if Resident 12 was unable to release his self-release buckle independently it was considered a restraint. The MDSC confirmed Resident 12's quarterly MDS was completed in January and Resident 12 was not reassessed for the use of the self-release belt at that time but should have been. The MDSC stated it was important for the assessment to have been completed because his condition could change.<br><br>A review of Resident 12's Restraint/Adaptive Equipment Use Assessment, dated, 2/26/25, indicated, . reassessment done on self release belt while in wheelchair, resident was unable to pull the self release belt open without cueing and further instruction .<br><br>A review of an undated, facility provided document titled, Know Your Rights under Federal Nursing Home Regulations, indicated, .You have the right to be free from physical .restraint .Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached to or near your body so that you can't remove the restraint easily. Physical restraints prevent your freedom of movement or normal access to your own body .<br><br>A review of a facility policy titled, Restraints -Physical, dated, 9/12/24, indicated, .[Facility] will attempt to provide an environment which is restraint free and discourages the use of restraints unless medically necessary, and when the safety and/or well-being of a resident is at risk examples of physical restraints as defined by CMS [Centers for Medicare & Medicaid Services] include but are not limited to .Leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily . the continued need for restraint is reevaluated no less than quarterly by the interdisciplinary team members . |

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| F 0656<br><br>Level of Harm - Minimal harm 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>50716<br><br>Based on observation, interview, and record review, the facility failed to ensure one of twenty two sampled residents (Resident 42), had a care plan (a formal process that identifies existing needs and recognizes potential needs or risks) developed to address Resident 42's oxygen needs and use.<br><br>This failure potentially contributed to Resident 42 not receiving the correct rate of oxygen (liters per minute-LPM. A unit of measure for oxygen delivery).<br><br>Findings:<br><br>During a concurrent observation and record review, on 2/26/25 at 10:03 AM in Resident 42's room, Licensed Nurse (LN) 6 confirmed Resident 42 was receiving oxygen at a rate of 2.5 LPM. LN 6 reviewed Resident 42's physician orders and confirmed Resident 42 should have been receiving oxygen at a rate of 4 LPM, continuously.<br><br>During a concurrent interview and record review on 2/26/25 at 12:09 PM, with LN 6, Resident 42's care plans were reviewed. LN 6 stated she was unable to locate an oxygen use care plan for Resident 42. LN 6 confirmed a care plan should have been created for Resident 42's oxygen needs and use. LN 6 further stated a care plan could have prevented Resident 42 from receiving an incorrect rate of oxygen. LN 6 explained the importance of a care plan was to have interventions in place as a guide for nurses to follow which helped them understand the plan of care.<br><br>During a concurrent interview and record review on 2/26/25 at 1:41 PM, the Director of Nursing (DON) confirmed an oxygen use care plan was never created for Resident 42. The DON stated a care plan was important because it gave the nurses interventions to look out for and a guide to follow. The DON further explained the risk to Resident 42 was a lower amount of oxygen being administered which could lead to shortness of breath, or other complications.<br><br>A review of a facility provided document for Resident 42 titled, General Order dated 7/23/2024, indicated, . Order Description: OXYGEN AT 4L/MIN [LPM] .CONTINUOUS .Order Class: Physician Order .<br><br>A review of a facility policy and procedure titled, Interdisciplinary Team/Care Plan Process, revised 12/2021, indicated, .An interdisciplinary assessment team .develops and maintains a comprehensive care plan . designed to .a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems . |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>51584<br><br>Based on observation, interview, and record review, the facility failed to ensure appropriate urinary catheter (a flexible tube inserted into the bladder used to drain urine) care and services were provided for one of two residents (Resident 71) with urinary catheters in a sample of 22 residents when:<br><br>1. Resident 71's urinary catheter bag (a device that attaches to the end of the tube to collect urine) was on the floor; and,<br><br>2. Resident 71's urinary catheter bag did not have a dignity cover (a cover that helps maintain the dignity of people who use catheters).<br><br>These failures had the potential to affect Resident 71's sense of self-worth and self-esteem and placed Resident 71, and others in the facility, at risk for adverse medical outcomes. (When a drainage bag on the floor touches or comes into contact with anything other than a clean surface, that item becomes contaminated, which could increase the chances of an infection for anyone that comes into contact with the contaminated item.)<br><br>Findings:<br><br>A review of Resident 71's Resident Face Sheet, indicated Resident 71 was admitted to the facility with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an infection) and bilateral hydronephrosis (a condition where both kidneys become enlarged due to a buildup of urine).<br><br>During a concurrent observation and interview on 2/25/25, at 4:47 PM, with Licensed Nurse (LN) 1 in Resident 71's room, LN 1 confirmed Resident 71 was lying in bed with his urinary catheter bag on the floor and the bag did not have a dignity cover. LN 1 stated that the catheter bag should be off the floor and should be covered. LN 1 added, there was a risk for contamination if the urinary catheter bag was left on the floor. LN 1 further stated having a dignity bag at all times would protect the resident's privacy and dignity.<br><br>During an interview on 2/27/25, at 1:57 PM, with LN 2, LN 2 stated that the urinary catheter bag should be placed below the bladder and attached to the bedrail when a resident was in bed for infection control prevention. LN 2 further stated the urinary catheter bag should have a dignity cover to protect the resident's privacy.<br><br>During an interview on 2/28/25, at 8:43 AM, with the Director of Nursing (DON), the DON stated that her expectation for the staff was to ensure the urinary catheter bags were off the floor and with a dignity cover at all times. The DON stated that the urinary catheter bag should not be on the floor because of a potential infection control risk. The DON added that the urinary catheter bag should be covered to protect the resident's dignity and privacy.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility policy and procedure titled, Bowel and Bladder Program - Indwelling Catheter, revised 2/1/25, indicated, .Residents with indwelling catheters .Catheter bags will be covered to maintain resident dignity .<br><br>According to the Center for Disease Control and Prevention - Healthcare Infection Control Practices Advisory Committee's Guideline for prevention of Catheter Associated Urinary Tract Infections 2009 updated April 12, 2024, indicated, .Proper Techniques for Urinary Catheter Maintenance .Do not rest the bag on the floor .<br><br>https://www.cdc.gov/infection-control/hcp/cauti/index.html |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>50716<br><br>Based on observation, interview, and record review, the facility failed to ensure respiratory care provided was consistent with professional standards of practice for 1 of 8 residents who received oxygen at the facility (Resident 42) when Resident 42's oxygen order was not followed.<br><br>This failure placed Resident 42 at risk for respiratory distress and inadequate treatment.<br><br>Findings:<br><br>During a concurrent observation and interview on 2/26/25 at 10:03 AM, with Licensed Nurse (LN) 6 in Resident 42's room, Resident 42 was observed receiving oxygen via nasal cannula (NC -a small flexible tube that contains two open prongs intended to sit inside the nostrils). LN 6 observed and confirmed the oxygen concentrator (a device that delivers oxygen) was on and running at 2.5 liters per minute (LPM, a unit of measure for oxygen delivery).<br><br>During a concurrent interview and record review on 2/26/25 at 10:05 AM, LN 6 reviewed Resident 42's current physician order for oxygen. LN 6 stated the physician's order for oxygen was 4 LPM. LN 6 confirmed the oxygen order was not being followed as prescribed by the physician. LN 6 stated the risk to the resident for not receiving the correct dose was hypoxia (a condition where there is not enough supply of oxygen to the body's tissue).<br><br>During an interview on 2/26/25 at 1:41 PM, with the Director of Nursing (DON), the DON confirmed the ordered amount of oxygen for Resident 42 was 4 LPM continuously. The DON stated the risk to the resident was Resident 42 could desaturate (to have low blood oxygen levels) or become short of breath. The DON explained it was important to follow the physician prescribed orders.<br><br>A review of a facility provided document for Resident 42 titled, General Order dated 7/23/2024, indicated, . Order Description: OXYGEN AT 4L/MIN [LPM] VIA NC CONTINUOUS .Order Class: Physician Order .<br><br>A review of the facility's policy and procedure titled, Oxygen Administration, revised 12/2021, indicated, .The licensed nurse will carry out the oxygen therapy orders . |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>50716<br><br>Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (% or percentage - number or ratio expressed as a fraction of 100) with a resident census of 67. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of 2 errors out of 36 opportunities which resulted in a facility wide medication error rate of 5.55% in 1 of 4 residents (Resident 234 ) observed for medication administration.<br><br>These failures had the potential to result in unsafe medication use and medication errors affecting the resident's health and well-being.<br><br>Findings:<br><br>During a medication administration observation, in the facility's Sequoia station, with Licensed Nurse (LN) 3, on 2/27/25 from 8:28 AM to 9:40 AM, the following observations were noted with medication administration to Resident 234 and Resident 79 as follows:<br><br>a. Resident 234's order for dorzolamide-timolol (an eye drop medication used to treat glaucoma [an eye disease that leads to vision loss]) .1 DROP .BOTH EYES FOR GLAUCOMA . was not administered during observation but was documented as given at 9 AM with a comment noted by LN 3, given as due.<br><br>b. Resident 234's order for Restasis (cyclosporine-an eye drop medication used to treat dry eyes) .1 DROP . BOTH EYES FOR GLAUCOMA . was not administered during observation but was documented as given at 9 AM with a comment noted by LN 3, given as due.<br><br>A review of Resident 234's Medications Administration History, dated 02/01/25 - 02/28/25, indicated, . dorzaloamide-timolol .Scheduled Date 02/27/2025, Scheduled Time: 09:00 [9AM], Charted Date: 2/27/2025 10:33 [AM] .Reason/Comments: Late Administration .Comment: given as due . The late medication administration documentation was made by LN 3.<br><br>A review of Resident 234's Medication Administration History, dated 02/01/25 - 02/28/25, indicated, .Restasis (cyclosporine) .Scheduled Date 02/27/2025, Scheduled Time: 09:00, Charted Date: 2/27/2025 10:33 . Reason/Comments: Late Administration .Comment: given as due . The late medication administration documentation was made by LN 3.<br><br>During an interview on 2/28/25 at 10:10 AM with the Director of Nursing (DON), the DON stated the expectation for passing medications would be for the nurses to not chart a medication was given if it was not given. The DON further stated the risk to the residents who did not receive medications as ordered, and missed doses of medication, was poor wound healing and not getting the required dose that was prescribed for a specific diagnosis.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's policy and procedure titled, Medication Administration dated 9/18, indicated, . Medications are to be administered in accordance with written orders of the prescriber .Medications are administered within 60 minutes of scheduled time .If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time .An explanatory note is entered . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50716<br><br>Based on observation, interview, and record review, the facility failed to ensure safe medication storage for a census of 67 when:<br><br>1. Employee's personal items were stored in two of two medication storage rooms (a locked room for storage of medication and supplies); and,<br><br>2. Expired medication was available for use in medication cart (a mobile cart containing medications used daily to give medications to the residents) #2, located on the Sequoia unit.<br><br>These failures may pose unsafe medication use in the facility.<br><br>Findings:<br><br>1a. During an inspection on [DATE] at 9:44 AM, of the facility's Sequoia unit medication room with Licensed Nurse (LN) 4, the cabinet under the sink was observed to contain employee's personal items. The following items were observed and confirmed with LN 4: An opened partial bottle of water in a plastic container, two coffee cups, and two tote style bags with personal belongings and a printed copy of the staffing schedule laying on top of one of the bags. All items were located under the sink.<br><br>1b. During an inspection on [DATE] at 4:15 PM, of the facility's Redwood/Harmony unit medication room with LN 5, the countertop contained a navy water bottle with a strap, a multicolored backpack, and a lunch box, all confirmed by LN 5. LN 5 stated the personal items belonged to staff. Under the sink another personal bag was observed and confirmed by LN 5. LN 5 stated staffs' personal belongings should not be in the medication rooms or under the sinks.<br><br>During an interview on [DATE] at 11:19 AM, the Administrator (ADM) stated staffs' personal belongings were not allowed in the medication rooms or under the sinks.<br><br>2. During an inspection on [DATE] at 12:02 PM, of medication cart #2, located on the Sequoia unit with LN 7, an opened foil package of Ipratropium bromide/albuterol (two medications in one for breathing problems) was found with an opened date of [DATE]. The label on the container indicated, .once removed from foil pouch, the individual vials should be used within two weeks . LN 7 confirmed the medication was expired and should have been removed from the medication cart. LN 7 further stated the risk to the resident's if given the Ipratropium bromide/albuterol was they could have a reaction to the medication, it could be too weak, and they would not get the right dose.<br><br>During an interview on [DATE] at 1:22 PM, with the Director of Nursing (DON), the DON stated the expectation for the medication Ipratropium bromide/albuterol was to remove it from the medication cart 14 days after the foil package was opened. The DON further stated the risk to the residents if given was the medication would not be as effective.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of a facility policy titled, Medication Storage (Nursing Care Center Pharmacy Policy & Procedure Manual -2007 PharMerica Corp), dated ,d+[DATE], indicated, .Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations .Medication storage should be kept clean .organized, free of clutter . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>47369<br><br>Based on observation, interview, and record review, the facility failed to prepare and serve food in accordance with professional standards of food service safety for eight residents who received soup for lunch on 2/27/25 when there was no temperature recorded for the soup prior to being served to those eight residents.<br><br>This failure put the eight residents who received soup from the kitchen on 2/27/25 at risk for food borne illness when it was unknown if the soup being served was in the safe temperature zone (above 140 Fahrenheit to prevent the growth of harmful bacteria).<br><br>Findings:<br><br>During a tray line observation on 2/27/25, at 11:45 AM, tomato soup was not available to fulfill a resident request. Dietary staff were observed heating a pan of soup on the stove and after several minutes a serving was provided to tray line staff. Seven separate servings of chicken noodle soup were observed being placed on meal trays.<br><br>A review of a facility recipe titled, Soup Tomato . indicated, .COOK-END TEMP 63 C [degrees Celsius] . (145. 4 degrees Fahrenheit)<br><br>A review of a facility recipe titled, Soup Chicken Noodle . indicated, .COOK-END TEMP 71 C . (159.8 degrees Fahrenheit)<br><br>During a concurrent interview and record review on 2/27/25, at 1:49 PM, the Certified Dietary Manager (CDM) confirmed the lunch time temperature log did not indicate a temperature check for the soups served during lunch time. The CDM confirmed the temperature should have been recorded to ensure the food temperature was in the safe zone to prevent food borne illness.<br><br>During an interview on 2/28/25, at 8:25 AM, [NAME] 1 stated she checked the food temperatures right before she began serving food and documented the temperatures on the log. [NAME] 1 stated every food item served required its temperature checked because people would get sick if food was served at the wrong temperature. [NAME] 1 stated if the temperature was incorrect the food would be reheated or cooled as appropriate.<br><br>A review of a facility document tiled, Time and Temperature Control, dated 2019, indicated, . Time and temperature are a perfect food safety pair, because to reduce pathogens [harmful germs] in food to safe levels, you have to cook the food to its correct minimum internal cooking temperature then hold the food at this temperature for a specific amount of time .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of a facility policy titled, Meal Temperature, dated 1/1/21, indicated, .All food items are evaluated for proper food temperature, taste, and appearance prior to meal service .The supervisor/designee must allow adequate time prior to meal service to record the temperatures of foods being served .An accurate temperature of all menu items is to be taken and recorded, utilizing an accurate thermometer .If hot food temperatures are not greater than or equal to the standards, or cold temperature are not less than or equal to the standards, respond accordingly to correct. Do not serve food at unacceptable temperatures . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>51285<br><br>Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 67, when:<br><br>1. Signage for Enhanced Barrier Precautions (EBP- a set of infection control measures that use gown and gloves to reduce the spread of multi-drug resistant organisms [MDRO- bacteria that are resistant to many antibiotics] and for people with medical devices that remain in the body for an extended period, providing continuous support or treatment) was not posted on, or near the doorway of Resident 335's room to alert staff to use personal protective equipment (PPE- protective clothing, gown, gloves, or other garments used to prevent the spread of germs) prior to entering the room; and,<br><br>2. PPE supplies were not available outside the rooms for Resident 14, Resident 35, Resident 42, and Resident 64 while on EBP.<br><br>These failures had the potential to spread infection and cause health problems to the residents, and staff, who live and work in the facility.<br><br>Findings:<br><br>1. A review of Resident 335's clinical record titled, Resident Face Sheet, indicated Resident 335 was admitted to the facility with diagnoses which included, cellulitis (a common bacterial infection of the skin and underlying tissues) on the back, and bacteremia-staph aureus (a serious bloodstream infection caused by the staph bacteria which can spread through skin-to-skin contact, contaminated surfaces, and shared items).<br><br>A review of an undated facility provided document titled, Residents on Isolation, indicated Resident 335 was on EBP.<br><br>A review of Resident 335's care plan titled, Care Plan .Resident requires IV [intravenous- within the vein] medication D/T [due to] STAPH AUREUS BACTEREMIA ., created on 2/20/25, which indicated, .Approach . ENHANCED BARRIER PRECAUTIONS .<br><br>During a concurrent observation and interview on 2/25/25, at 9:51 a.m., with the Unit Manager/Case Manager (UM/CM) in the hallway outside of Resident 335's room, the UM/CM confirmed Resident 335 was on an IV antibiotic to treat his infection. The UM/CM further confirmed no EBP sign was placed at the doorway to indicate the type of isolation and what PPE was required for staff when taking care of Resident 335. The UM/CM stated not placing the isolation sign could contribute to the spread of infection in the facility.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 2/26/25, at 10:14 a.m., with the Infection Preventionist (IP), the IP confirmed that Resident 335 was on the list of residents on EBP due to having staph aureus bacteremia. The IP stated that if a resident was on EBP there should be an EBP sign posted on, or near the doorway of the resident's room. The IP further stated that it was her expectation for nursing staff to post an EBP sign outside of the room, so staff could don (put on) the appropriate PPE prior to entering the resident's room. The IP stated the isolation precaution sign was a method of communication to inform staff about the type of isolation and required PPE. The IP further stated there was a potential risk to spread infection in the facility due to not having EBP signage posted on, or near the doorway of the resident's room.<br><br>During a concurrent interview and record review on 2/26/25, at 11 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Isolation Precautions, Categories Of, revised 1/27/25, was reviewed. The P&P indicated, .Transmission-based isolation precautions will be used for residents who are documented or suspected to have infections or communicable diseases that can be transmitted .f) Signs - A sign will be used to alert staff and visitors of the implementation of isolation precautions, while protecting the privacy of the resident . The DON stated that it was her expectation to have an EBP sign posted outside by the room's entrance door for staff to ensure the required PPE was worn. The DON further stated she expected staff to follow the facility's P&P for isolation precautions. The DON confirmed the facility's P&P for isolation precautions was not followed. The DON stated there was a potential risk of spreading infection in the facility when signage was not used.<br><br>2a. Review of Resident 35's medical record titled, Resident Face Sheet, indicated that Resident 35 was admitted to the facility with diagnoses that included chronic kidney disease stage 4 (a condition when the kidneys are severely damaged and only functioning at a very low level) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).<br><br>Review of Resident 35's Care Plan History, initiated on 2/25/25, indicated .Problem .HISTORY OF antibiotic resistant infection VRE [Vancomycin-resistant enterococci - a type of bacteria that is present in the stomach and intestines that develop resistance to many antibiotics, especially vancomycin] .Approach .Enhanced Barrier Precautions .<br><br>During a concurrent interview and record review with the Infection Preventionist (IP), on 2/26/25, at 9:53 a.m. , the IP confirmed that Resident 35 was on the list of residents on EBP due to having a dialysis port and a history of VRE. The IP stated that it was expected for staff to wear PPE like gowns and gloves during high contact activities for residents on EBP. The IP further stated that the PPE supplies should be in the linen closets and central supply rooms. The IP stated that the Certified Nurse Assistants (CNA) were supposed to gather the supplies before entering the resident's room. The IP confirmed that the PPE should be readily available for staff. The IP confirmed that Resident 35 was at higher risk for infection due to having a dialysis port in place. The IP stated that it was her expectation for all LN and CNA staff to know and follow precautions and policies for all types of contact precautions in place.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview with LN 2, on 2/27/25, at 10:53 a.m., LN 2 confirmed that an EBP sign was posted outside of Resident 35's room but there was no PPE bin (a container used to store PPE) outside of Resident 35's room. LN 2 confirmed that the PPE gowns were located inside Resident 35's room right by the doorway and the gloves were inside Resident 35's bathroom. LN 2 stated that the staff should don the PPE before direct contact with Resident 35. LN 2 added that the risk of not having the PPE supplies outside of the EBP room would be for possible infection and cross contamination. LN 2 further stated that Resident 35 would be at greater risk of infection due to having the dialysis port in place for dialysis treatments.<br><br>During an interview with the DON, on 2/27/25, at 12:47 p.m., the DON stated that if a resident was on EBP that there should be an EBP sign posted outside the entrance of the room and an isolation cart or PPE bin should also be outside of the room. The DON further stated that EBP was in place for residents with wounds, feeding tubes (a tube placed in the stomach that provides nutrition), urinary catheters (a tube that drains urine from the bladder into a collection bag), and dialysis ports. The DON stated that it was her expectation for staff to be gowning up and using the PPE when providing care to residents. The DON stated that the IP usually had the PPE bins outside the room so the staff can don the PPE before entering the resident's room. The DON stated that it was her expectation to have the PPE bin outside the room for staff to don the PPE. The DON stated that the risk of not having the PPE supplies outside the room was for infection to spread and the main goal was to prevent and contain any infection.<br><br>2b. Review of Resident 64's medical record titled, Resident Face Sheet, indicated that Resident 64 was admitted to the facility with diagnoses that included aftercare following right hip joint surgery, fracture of neck of right femur (upper part of the thigh) and pressure ulcer of sacral region stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the base of the spine area).<br><br>During an interview with Resident 64, on 2/26/25, at 9:06 a.m., Resident 64 stated that she had a pressure wound on her bottom that had been going on for a year now. Resident 64 stated that her pressure wound dressing was changed three times a week on Mondays, Wednesdays, and Fridays.<br><br>During a concurrent observation and interview with Certified Nurse Assistant (CNA) 3, on 2/26/25, at 9:13 a.m., CNA 3 confirmed that Resident 64 had an EBP sign posted outside the room's doorway and stated that it was her first time seeing the sign. CNA 3 stated that there was no mention of a reason why Resident 64 was on EBP. CNA 3 stated that she knew that Resident 64 had an open wound on her bottom but was covered and treated by the wound nurse. CNA 3 stated that if a resident was on EBP, staff were supposed to use PPE like gloves, gowns, and a mask when providing care. CNA 3 confirmed that there was no PPE bin outside the doorway of Resident 64's room. CNA 3 stated that the risk of not having PPE supplies was for the resident to get an infection or for cross contamination. CNA 3 further stated that Resident 64 was at higher risk for infection due to her having the pressure ulcer wound on her bottom.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview with LN 4, on 2/26/25, at 9:27 a.m., LN 4 confirmed that an EBP sign was posted outside Resident 64's doorway. LN 4 confirmed that Resident 64 had a stage 4 pressure ulcer. When asked where the PPE supplies should be located, LN 4 stated that the PPE should be within the first wall of the resident's room upon entrance. LN 4 confirmed that a hand sanitizer and PPE gowns were placed by the doorway inside Resident 64's room close to the restroom door. LN 4 stated that the gloves were inside Resident 64's restroom or in the medication cart. LN 4 confirmed that there was no PPE bin outside Resident 64's doorway. LN 4 stated that the risk of not having PPE supplies readily available would be for infection and cross contamination. LN 4 stated that Resident 64 would be at greater risk of infection due to being diabetic (inability to regulate sugar levels in the body) and having the pressure ulcer.<br><br>During a concurrent interview and record review with the Infection Preventionist (IP), on 2/26/25, at 9:53 a.m. , the IP confirmed that Resident 64 was on the list of residents on EBP due to having a stage 4 pressure ulcer. The IP stated that it was expected for staff to wear PPE like gowns and gloves during high contact activities for residents on EBP. The IP added that the CNA should be aware if residents were on any precautions and the LN should know the reason for the precautions in place. The IP confirmed that Resident 64 was at higher risk for infection due to being diabetic and with the presence of the pressure ulcer.<br><br>Review of Resident 64's Care Plan History, initiated on 2/25/25, indicated .Problem .Pressure Ulcer/Injury ALTERATION IN SKIN INTEGRITY - STAGE 4, PRESSURE ULCER .Approach .Enhanced Barrier Precautions .<br><br>During a concurrent interview and record review with LN 2, on 2/27/25, at 10:13 a.m., LN 2 reviewed Resident 64's EHR and confirmed that Resident 64 had a care plan, dated 2/25/25, that indicated EBP was in place related to an unhealed wound.<br><br>2c. During a concurrent observation and interview on 2/25/25 at 9:28 AM, in front of Resident 42's room with LN 6, an EBP sign was observed at the entrance to Resident 42's room. LN 6 stated Resident 42 was on EBP due to a Stage III Pressure Ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or a pressure in combination with friction) located on Resident 42's back. LN 6 further stated Resident 42 had wound care with dressing changes every Monday, Wednesday, and Friday. LN 6 confirmed Resident 42 did not have PPE (gown and gloves) at the entrance to the room since it was kept on the medication cart (a locked rolling cart stocked with medication and supplies) and in the utility room.<br><br>During a concurrent observation and interview on 2/25/25 at 10:23 AM the Director of Staff Development (DSD) confirmed PPE was not available for use outside of Resident 42's room and stated it was supposed to be.<br><br>2d. During a concurrent observation and interview on 2/25/25 at 10:13 AM, inside of Resident 14's room, CNA 2 was observed in PPE while caring for Resident 14. CNA 2 stated Resident 14 had a gastrostomy tube (GT - a tube that is surgically inserted into the resident's stomach to allow access for fluids, nutrition, and medications) and was on EBP requiring PPE which included a gown and gloves while performing resident care. An EBP sign was confirmed to be on the door at the entrance to the room. CNA 2 confirmed there were no PPE supplies available at the entrance of the room. CNA 2 stated she retrieved the PPE from the utility room, prior to entering Resident 14's room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555713 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/28/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Meadowood A Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 2/25/25 at 10:23 AM the Director of Staff Development (DSD) confirmed PPE was not available for use outside of Resident 14's room and stated it was supposed to be.<br><br>During an interview on 2/26/25 at 1:38 PM with the DON, the DON stated her expectation for residents on EBP precautions, was for the PPE to be available at the doorway. The DON further stated the staff should not have to go looking for PPE. The DON explained the risk to the residents for not having PPE available was infection or the spread of infection from residents to staff, or staff to residents.<br><br>Review of the Centers for Disease Control (CDC) website, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, indicated .When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies .Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) .For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves .Make PPE, including gowns and gloves, available immediately outside of the resident room .<br><br>(https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html) |