STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555490	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowood Nursing Center	3805 Dexter Lane Clearlake, CA 95422

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free of significant medication errors when Resident 1's order for suboxone (prescription medication used to treat opioid use disorder by reducing cravings and withdrawal symptoms) was not renewed timely and the medication was not available for administration.This failure had the potential to result in Resident 1 experiencing withdrawal symptoms (the physical and psychological symptoms that occur when stopping or reducing the use of addictive substances).Findings:A review of Resident 1's admission record indicated he was admitted to the facility on [DATE] with a diagnosis of substance dependence (condition where a person's body and mind have adapted to regular drug or alcohol use to the point that they feel they need the substance to function normally).During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/27/26, indicated he had no memory impairment.During a review of Resident 1's medication administration record (MAR) for the month of 2/26, indicated Resident 1 did not receive his suboxone (chart code 9 = other/see Nurse Notes) on 2/23/26 at 6 p.m., on 2/24/26 at 8 a.m., and on 2/24/26 at 4 p.m.During a review of Resident 1's Progress Notes (PNs), the PNs indicated:PN, dated 2/4/26 at 4:15 p.m., a physician's order note for suboxone, sublingual Film 8-2 milligram (mg, a unit of measurement), Buprenorphine HCl-Naloxone HCl dihydrate, 1 film sublingually three times a day for opioid dependence.PN, dated 2/23/26 at 5:05 p.m., suboxone sublingual film is pending pharmacy delivery.PN, dated 2/24/26 at 8:08 a.m., suboxone sublingual film was not given.PN, dated 2/24/26 at 1:09 p.m., suboxone sublingual film was unavailable due to the order pending the signature of the physician.PN, dated 2/24/26 6:19 p.m., suboxone sublingual film is pending delivery. During an interview on 3/17/26 at 11:59 a.m. with Resident 1, Resident 1 stated he had not received his suboxone for a week, he had no idea why, and he had experienced shaking and anxiety due to the missed doses. He further stated he was a recovering heroin (a highly addictive opioid drug) addict.During a concurrent interview and record reviedw on 3/17/26 at 12:34 p.m. with the Assistant Director of Nursing (ADON), Resident 1's MAR, dated 2/2026, and Resident 1's PNs, dated 2/23-2/24/26, were reviewed. The ADON stated it was her expectation residents' medications were available for administration and doses were not missed. The ADON reviewed Resident 1's 2/2026 MAR and confirmed Resident 1 had missed one dose of suboxone on 2/23/26 and two doses on 2/24/26. The ADON stated she did not know why the suboxone was not given. The ADON reviewed Resident 1's PNs and confirmed the medication had not been available for administration. The ADON stated it was her expectation nursing ordered the medication timely so that it was available for administration. The ADON further stated if Resident 1 was given suboxone for opioid dependence, not receiving his medication could result in him experiencing withdrawal symptoms.During a concurrent interview and record review on 3/17/26 at 2:58 p.m. with the ADON, the ADON reviewed Resident 1's 2/4/26 PN and confirmed suboxone had been prescribed for opioid dependence and agreed that if Resident 1 had complained he had experienced anxiety and shakiness due to the missed doses it was a significant medication error for him.During a review of the facility's policy titled, Medication Reordering dated 10/25, the policy indicated, It is the policy of the facility to accurately and safely (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident.During a review of the facility's policy titled, Medication Errors, dated 10/25, the policy indicated, It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services in an environment free of significant medication errors.