STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375256	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowlake Estates	959 Southwest 107th Street Oklahoma City, OK 73139

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 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, record review, and interview, the facility failed to ensure medications were stored securely to prevent unauthorized access during 1 of 2 observations of medication storage.The DON identified 109 residents received medication from the facility.Findings:On 03/25/26 at 10:25 a.m., a white pill identified as a 100 mg gabapentin (an anticonvulsant) was observed laying on top of a medication cart in the hall outside of a resident's room. There was no staff in sight of the medication cart.A facility policy titled Medication Administration General Guidelines, dated 01/2024, read in part, 17. During administration of medications, the medications cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering the medications when unlocked.On 03/25/26 at 10:30 a.m., the DON was shown the pill located on top of the medication cart. The DON stated the pill was a 100 mg gabapentin (an anticonvulsant). The DON stated a resident could have picked up the pill and consumed it. On 03/25/26 at 11:45 a.m., RN #1 stated they punched a 100 mg gabapentin (an anticonvulsant) pill from the card to administer it to a resident. RN #1 stated the pill dropped, and they were unable to locate it. RN #1 stated they got another pill and administered it to the resident. RN #1 stated they did not notify the DON. RN #1 stated another resident could have come by and taken the medication. On 03/31/26 at 12:51 p.m., the DON stated the pill was found unattended on top of the medication cart. The DON stated when RN #1 could not locate the missing medication, RN #1 should have notified someone to help look for the missing medication. The DON stated the pill was found visible on top of the cart where another resident could have consumed the medication. The DON stated all medications should be stored safely and the pill was not stored to prevent unauthorized access to it.

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