| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375276 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/16/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Meadowbrook Nursing Center | 113 East Jones<br>Chouteau, OK 74337 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, and interview, the facility failed to ensure adequate supervision to prevent an elopement for 1 (#1) of 3 sampled residents reviewed for elopement.The administrator identified 28 residents who resided in the facility.Findings:On 04/15/26 at 12:07 p.m., Res #1 was observed in their room sitting on the side of their bed. Res #1 was observed to be clean and dressed appropriately.On 04/16/26 at 10:45 a.m., Res #1 was observed resting in bed with their eyes closed.On 04/16/26 at 2:00 p.m., Res #1 was observed in their room sitting on the side of their bed looking through papers.An undated policy titled Missing Resident, read in part, It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable. This is with the intent of not invading privacy but to identify a possible missing resident.An undated face sheet showed Res #1 admitted to the facility with diagnoses which included congestive heart failure and hypertension.An elopement assessment, dated 02/12/26, showed Res #1 was not at risk for elopement.A significant change assessment, dated 02/13/26, showed Res #1 had a brief interview for mental status score of 13 which indicated the resident was cognitively intact for daily decision making. The assessment showed Res #1 was ambulatory with the use of a walker.An initial incident report, dated 04/04/26, showed the nurse was at the nurse's station charting when they were informed Res #1 was out of the building and walking towards the highway. The report showed Res #1 walked onto the highway and stood in front of a semi-truck that had stopped and asked the driver to take them home. The report showed staff were eventually able to get Res #1 back to the facility safely without any injuries. The report showed Res #1 was placed on one-on-one supervision and referrals were made to a geriatric-psychiatric facility for review. The report showed the administrator, DON, and physician were notified. The report showed Res #1's family member was notified of the elopement on 04/04/26 at 9:50 p.m.A typed statement from Res #1, dated 04/06/26, showed Res #1 was angry because their family member would not answer their questions and hung up on them. The statement showed Res #1 walked slowly down the hallway while waiting for the nurse to leave. The statement showed Res #1 saw the nurse was no longer at the desk and hurried to the door and entered the code. The statement showed Res #1 went out the door and continued down the road toward the highway. The statement showed Res#1 moved slowly toward the edge of the road until a passing truck stopped and they asked the driver to take them home. The statement showed nurses and other staff arrived and returned Res #1 to the facility. The note showed Res #1 asked the staff to type their statement.A final incident report, dated 04/09/26, showed the following measures were implemented:a. On 04/04/26, Res #1 was placed on one-on-one supervision; exit door codes were changed; a psychiatric hospital referral was made at Res #1's request; and Res #1's family member was notified of the elopement.b. On 04/05/26, Res #1's care plan was updated to address elopement.c. On 04/06/26, new assessments for elopement, pain, and skin were completed for Res #1; elopement observations were completed on all residents; a medication review was ordered; the ombudsman was notified and asked to assist with concerns regarding Res #1's home and bank account involving a family member; social services completed questionnaires regarding elopement risk and desire to leave the facility; and signage was posted on exit doors reminding staff and visitors<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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 375276 | A. Building<br>B. Wing | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| --- | --- |
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to remain alert, as the residents may resemble visitors. d. On 04/06/26, Res #1 was admitted to a geriatric psychiatric facility.e. To prevent reoccurrence, the facility will update elopement/wandering observations quarterly and as needed; maintain an updated elopement log at the nurse's station for at-risk residents; ensure exit door codes remain current; and post alerts on front doors to notify staff and visitors upon exit.A Quality Assurance and Performance Improvement meeting agenda, dated 04/10/26, showed elopement/accidents were addressed in the meeting.A nurse note, dated 04/14/26, showed Res #1 returned from the geriatric psychiatric facility.On 04/15/26 at 12:07 p.m., Res #1 stated they had just returned from the hospital. Res #1 stated I needed that. Res #1 stated the day they left the facility; they were having a bad day and had just wanted to go home to check on their house because their family member hung up on them when they called. Res #1 stated I did not walk out in front of that truck until it had stopped.On 04/15/26 at 2:45 p.m., the corporate nurse consultant stated the resident should have never been able to leave the building unattended. |