STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515134	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Acres	2149 Greenbrier Street Charleston, WV 25311

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, and staff interview the facility failed to provide residents with a dignified activity experience by passing medications during Bible Study. This failed practice was a random opportunity for discovery during the Complaint Survey. Resident identifier #9. Facility Census 58.Findings Include:a) Resident #9An observation on 11/04/25 at 2:18 PM, revealed the recreation room door to be closed and a sign that read, Bible Study on the closed door.Further observation revealed Registered Nurse (RN) #48, opening the closed door that read, Bible Study and administering Resident #9 a medication.During an interview on 11/04/25 at 2:30, RN #48 stated, If we are running behind we give them during activities or in the dining room. SA asked the RN if he was behind today and RN #48 stated, Not really, I just wanted to get done. SA then asked what medication did you give the resident? RN #48 replied, Baclofen.During an interview on 11/04/25 at 3:14 PM, Activity Assistant (AA) #73 confirmed that the RN gave the medicine during Bible Study and stated, They give medicines in all of our activities.A policy review on 11/04/25 at 3:30 PM, revealed a policy titled {Medication Administration}, {Policy Explanation and Compliance Guidelines}, under bulletin seven (7) reads; Provide Privacy

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 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 record review, and staff interview the facility neglected to provide supervision and monitoring to prevent repeated elopement's. This failed practice resulted in Resident #60 having over 20 attempted elopement's and/or exit seeking behaviors during a (9) nine month period. This failed practice was found true for (1) one of (3) three residents reviewed for elopement risk during the Complaint Survey Process. Resident identifier #60. Facility Census 58.Findings Include:a) Resident #60A review on 11/04/25 at 2:15 PM, revealed a reportable incident for Resident #60 for an elopement dated 04/22/24. The elopement is summarized as follows: On 04/22/24 the facility received a phone call from a (Local Emergency Room) saying that Resident #60 had been brought in by someone and that she had eloped from this nursing home. During the investigation it was determined by medical records and staff interviews that when (3) three evening shift staff members entered the facility they did not make sure the door properly latched making the elopement possible. It was also determined during the investigation by the facility that the resident had been gone for approximately 2 hours, according to the statements, meal tickets and medication administration times. A record review on 11/05/25 at 10:40 AM, revealed Nursing Notes, and Behavior Notes from 09/2023 to 04/22/24 showing that Resident #60 was exit seeking, or had went out the front door, A hall door, or B hall door at least 20 times. Further record review of Resident #60's incidents revealed that between 9/2023 to 04/22/24, five (5) of the elopement attempts were successful and Resident #60 did get out of the facility. Further record review also revealed that Resident #60 had (3) three scheduled wandering risk assessments completed, which all had her at risk for elopement, and that A wander guard bracelet had been placed since admission.Continued record review revealed an elopement care plan created on 04/14/23 that had only the following interventions until her elopement on 04/22/24:Attempt to involve (Resident #60 name) in activities of choice for as long as shewill maintain focus even though it's for short periodsDate Initiated: 04/23/2024Distract (Resident #60 name) from wandering by offering pleasant diversions,structured activities, food, conversation, television, take outside in the court yardwhen weather is nice and give her the baby doll. Date Initiated: 04/14/2023 WANDER ALERT: Wander guard bracelet to be worn at all timesand applied to right ankle.Date Initiated: 04/14/2023Check wander guard bracelet at bedtime for proper function andplacementDate Initiated: 04/14/2023Report any exit seeking behaviors to nursing and SupervisorDate Initiated: 04/14/2023Wander guard bracelet to be changed yearly per recommendationsand PRN for non-functioning device.Date Initiated: 04/14/202During an interview on 11/05/25 at 1:45 PM, with The Director of Nursing (DON), and Licensed Social Worker (LSW), The DON stated, I know 360 Psych had seen her, and she had a couple infections. The LSW stated, I know I talked to her family about moving her to a locked unit, but they wouldn't agree, but I don't have that documented anywhere. The DON further stated, I started as DON in September of 2023. I had never been in Long-Term Care. My mind then wasn't what it is now. Looking back on it I would of put her on one on one visits or at least 15 minute checks.b) PolicyA review on 11/05/25 at 2:30 PM of the policy last reviewed on 04/01/13 titled {Elopement/Missing Resident protocol, defines elopement as follows: When a resident leaves the premises or safe area without authorization. A resident who leaves the premises has the potential to experience heat/cold exposure, dehydration and/or medical complications, drowning or being struck by a vehicle.Purpose:To initiate emergency protocol should a resident exit the facility unescorted by staff member or legally responsible party. Resident straying beyond the normal view or control of employees may be at risk for injury or death. During an interview on 11/05/25 at 2:45 PM, the DON confirmed that the above policy was the one in place when the elopement took place on 04/22/24, and that a new policy has been put in place since. The DON further stated, I noticed our policy had not been reviewed since 2013 and got us a new one.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and staff interview the facility failed to develop and implement the care plan for applying bed rails to the beds. This was true for three (3) of the eleven (11) residents that were reviewed for bed rails. Resident Identifiers: #49, #30 and #19. Facility Census: 58 Findings Include: a) Resident #49 On 11/04/25 at 10:10 AM record review of current orders for Resident #49 shows 1/2 bilateral upper siderails to assist with bed mobility and transfers. On 11/04/25 at 10:20 AM review of the care plan for Focus (Residents name) hasd an ADL self care performance deficit related to deconditioning, weakness, pain. Resident #49s interventions./tasks show Bilateral 1/2 side rail to aid in turning and repositioning. On 11/04/25 at 10:45 AM observation of Resident #49 shows she has no side rails in place at this time. The above findings were confirmed with the Director of Nursing on 11/05/25 at 9:15 AM at which time she agreed there were no side rails present on the bed. b) Resident #30 A record review on 11/04/25 at 10:30 AM, revealed a fall care plan for Resident #30, that has an intervention implemented on 08/018/25 that reads as follows: Half bilateral side rails to head of bed for increased independence with positioning and personal care. An observation on 11/04/25 at 10:40 AM, revealed Resident #30 lying in bed, no side rails in place per the care plan. During an interview on 11/04/25 at 10:45 AM, The Director of Nursing (DON), confirmed that the side rails were not on Resident #30's bed as care planned. c) Resident #19 A record review on 11/05/25 at 12:25 pm, revealed a Care Plan order for Resident #19, completed on10/13/2025 that reads as follows: Resident #19 (name) has been approved for use of bilateral quarter side rails for assisting with repositioning and bed mobility. An observation on 11/06/25 at 9:40 AM, revealed the resident lying in bed, no bilateral quarter side rails in place per order. During an interview on 11/06/25 at 1:45 PM, The Director of Nursing (DON) acknowledged that the side rails were not in place as ordered for Resident #19.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, staff interview, and observation the facility failed to provide care in accordance with professional standards of practice, by not following doctors orders for side rail implementation and neuro checks. This failed practice was found true for (4) four of (4) four residents reviewed for fall interventions during the Complaint Survey Process. Resident identifiers #19, #30, #49, and #23. Facility Census 58. Findings Include: a) Resident #49 On 11/04/25 at 10:10 AM record review of current orders for Resident #49 shows 1/2 bilateral upper siderails to assist with bed mobility and transfers ordered on 08/14/24. The care plan for Focus (Residents name) hasd an ADL self care performance deficit related to deconditioning, weakness, pain. Resident #49s interventions./tasks show Bilateral 1/2 side rail to aid in turning and repositioning. A review of Task GG Roll Left and Right shows Resident #49 is either Partial.moderate assistance or Substantial.maximal asistance for turns. On 11/04/25 at 10:45 AM observation of Resident #49 shows she has no side rails in place at this time. The above findings were confirmed with the Director of Nursing on 11/05/25 at 9:15 AM at which time she agreed there were no side rails present on the bed. b) Resident #23 On 11/04/25 at 12:40 PM record review found that Resident #23 has had several unwitnessed falls since her admission. The Change in Condition report was obtained and reviewed which shows an unwitnessed fall on 10/31/25 at 9:30 AM which occurred in the lounge. The Incident description reads resident was observed on floor in front of couch. The Resident description reads resident states she slid off the couch. According to the Neurological Evaluation Policy as of 01/26/23 which was provided to the surveyor, Neurological evalutaion will be performed as indicated or ordered. When a Resident sustains an injury to the head or has an unwitnessed fall the following evlauations will be performed: Every 15 minutes X one hour Every 30 minutes X two hours Every 60 minutes X four hours Every 8 hours until 72 hours (3 days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/04/25 at 2:10 PM the Director of Nursing stated neurological checks are performed on all residents that have an unwitnessed fall. She also stated that there are no neurological assessments for Resident #23 for the unwitnessed fall on 10/31/25 and they should have been performed. c) Resident #19 A record review on 11/05/25 at 12:25 pm, revealed a Care Plan order for Resident #19, completed on10/13/2025 that reads as follows: Resident #19 (name) has been approved for use of bilateral quarter side rails for assisting with repositioning and bed mobility. An observation on 11/06/25 at 9:40 AM, revealed the resident lying in bed, no bilateral quarter side rails in place per order. During an interview on 11/06/25 at 1:45 PM, The Director of Nursing (DON) acknowledged that the side rails were not in place as ordered for Resident #19. b) Resident #30 A record review on 11/04/25 at 10:30 AM, revealed an order for Resident #30, dated 08/18/25 that reads as follows: Half bilateral side rails to head of bed for increased independence with positioning and personal care. An observation on 11/04/25 at 10:30 AM, revealed the resident lying in bed, no half bilateral side rails in place per order. During an interview on 11/04/25 at 10:45 AM, The Director of Nursing (DON) confirmed that the side rails were not in place as ordered for Resident #30 and stated, We did an audit a few weeks back and that is her new bed. I did not do a new assessment. I guess I dropped the ball on that one.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, and staff interview the facility failed to ensure the environment in which it had control over was as free from accidents/ hazards as possible, by not providing supervision and monitoring to prevent repeated elopements. This failed practice was found true for (1) one of (3) three residents reviewed for elopement risk during the Complaint Survey Process. Resident identifier #60. Facility Census 58. Findings Include:a) Resident #60A review on 11/04/25 at 2:15 PM, revealed a reportable incident for Resident #60 for an elopement dated 04/22/24. The elopement is summarized as follows: On 04/22/24 the facility received a phone call from a (Local Emergency Room) saying that Resident #60 had been brought in by someone and that she had eloped from this nursing home. During the investigation it was determined by medical records and staff interviews that when (3) three evening shift staff members entered the facility they did not make sure the door properly latched making the elopement possible. It was also determined during the investigation by the facility that the resident had been gone for approximately 2 hours, according to the statements, meal tickets and medication administration times. A record review on 11/05/25 at 10:40 AM, revealed Nursing Notes, and Behavior Notes from 09/2023 to 04/22/24 showing that Resident #60 was exit seeking, or had went out the front door, A hall door, or B hall door at least 20 times. Further record review of Resident #60's incidents revealed that between 9/2023 to 04/22/24, five (5) of the elopement attempts were successful and Resident #60 did get out of the facility. Further record review also revealed that Resident #60 had (3) three scheduled wandering risk assessments completed, which all had her at risk for elopement, and that A wander guard bracelet had been placed since admission.Continued record review revealed an elopement care plan created on 04/14/23 that had only the following interventions until her elopement on 04/22/24:Attempt to involve (Resident #60 name) in activities of choice for as long as shewill maintain focus even though it's for short periodsDate Initiated: 04/23/2024Distract (Resident #60 name) from wandering by offering pleasant diversions,structured activities, food, conversation, television, take outside in the court yardwhen weather is nice and give her the baby doll.Date Initiated: 04/14/2023 WANDER ALERT: Wander guard bracelet to be worn at all timesand applied to right ankle.Date Initiated: 04/14/2023Check wander guard bracelet at bedtime for proper function andplacementDate Initiated: 04/14/2023Report any exit seeking behaviors to nursing and SupervisorDate Initiated: 04/14/2023Wander guard bracelet to be changed yearly per recommendationsand PRN for non-functioning device.Date Initiated: 04/14/202During an interview on 11/05/25 at 1:45 PM, with The Director of Nursing (DON), and Licensed Social Worker (LSW), The DON stated, I know 360 Psych had seen her, and she had a couple infections. The LSW stated, I know I talked to her family about moving her to a locked unit, but they wouldn't agree, but I don't have that documented anywhere. The DON further stated, I started as DON in September of 2023. I had never been in Long-Term Care. My mind then wasn't what it is now. Looking back on it I would of put her on one on one visits or at least 15 minute checks.b) PolicyA review on 11/05/25 at 2:30 PM of the policy last reviewed on 04/01/13 titled {Elopement/Missing Resident protocol, defines elopement as follows: When a resident leaves the premises or safe area without authorization. A resident who leaves the premises has the potential to experience heat/cold exposure, dehydration and/or medical complications, drowning or being struck by a vehicle.Purpose:To initiate emergency protocol should a resident exit the facility unescorted by staff member or legally responsible party. Resident straying beyond the normal view or control of employees may be at risk for injury or death. During an interview on 11/05/25 at 2:45 PM, the DON confirmed that the above policy was the one in place when the elopement took place on 04/22/24, and that a new policy has been put in place since. The DON further stated, I noticed our policy had not been reviewed since 2013 and got us a new one.