

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Midwest City Post Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 National Avenue Midwest City, OK 73110	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were treated with respect and dignity for 1 (#1) of 3 sampled residents reviewed for respect and dignity. The administrator identified 72 residents resided in the facility. Findings: On 08/12/25 at 4:22 p.m., Resident #1 was observed sitting on hall 2 in a wheelchair with a t-shirt and a brief. An undated facility policy Resident Rights, read in part, The facility will treat each resident with respect and dignity and care for each resident in a manner and environment that promotes her quality of life, recognizing each resident's individuality. An undated diagnosis sheet, showed Resident #1 had a diagnosis of anoxic brain damage, required assistance with personal care, epilepsy, generalized anxiety disorder and depression. A care plan, dated 06/03/25, read in part, Assist Resident #1 with dressing. [Resident #1] has impaired cognitive function/dementia or impaired thought processes, impaired decision making, neurological symptoms. On 08/12/25 at 4:23 p.m., CMA #1 stated it was not okay for Resident #1 to sit on the hallways without being covered by a towel or blanket. On 08/12/25 at 4:33 p.m., the DON stated staff should have covered Resident #1 with a blanket or towel.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a medication cart was locked when unsupervised for 1 of 3 medication carts used for dispensing medications. The DON of identified 72 residents resided in the facility. Findings: On 08/12/25 at 2:53 p.m., the medication cart on hall 300 was observed to be unlocked and unattended blocking the doorway in front of room [ROOM NUMBER]. On 08/12/25 at 2:54 p.m., upon entering room [ROOM NUMBER], LPN #1 was observed standing behind the closed curtain. An undated facility policy titled Medication Storage and Handling, read in part, 3. The Medication Cart will always be locked unless it is in direct view of the Unit Nurse. No medications should be left unattended: In resident's rooms, on medication carts, At the Nurse's stations. On 08/12/25 at 2:55 p.m., LPN #1 stated they could not see the medication cart because they were standing behind the curtain, blocking their view of the medication cart. On 08/12/25 at 2:56 p.m., LPN #1 stated the medication cart should be locked when someone has stepped away from the medication cart. On 08/12/25 at 4:34 p.m. the DON stated medication carts should be locked and supervised at all times.</p>		