STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375252	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwest City Post Acute & Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 2 (#5 and #6) of 3 sampled residents reviewed for timely administration of medications. The DON identified 99 residents received medications in the facility. Findings:An Administering Medications policy, revised 04/2019, read in part, Medications are administered in accordance with prescriber orders, including any required time fame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 1. A significant change assessment for Resident #5, dated 04/28/26, showed the resident had a brief interview for mental status score of 15 indicating their cognition was in intact. A June 2026 MAR for Resident #5 showed they were to be given 0.25 mg of alprazolam (an antianxiety medication) by mouth two times a day for anxiety. An Administration Note, dated 06/21/26 at 5:24 p.m., showed alprazolam was not given because the staff was waiting on pharmacy.An Administration Note, dated 06/22/26 at 7:00 a.m., showed alprazolam was not given because the staff was waiting on delivery.An Administration Note, dated 06/22/26 at 3:11 p.m., showed alprazolam was not given because the staff was waiting on pharmacy.An Administration Note, dated 06/23/26 at 9:22 a.m., showed alprazolam was not given because meds ordered.On 06/25/26 at 3:10 p.m., Resident #5 stated last week they did not get their anxiety medication for several days because the facility ran out.On 06/25/26 at 3:52 p.m., the DON stated medications should be ordered early enough to be available in the facility before the resident ran out of medication. The DON was unable to articulate why the medication was not available in the facility to be given as ordered.2. An Order Summary for Resident #6, dated 06/2026, showed the resident was to receive:a. memantine (a central nervous system agent used to treat Alzheimers) 5 mg 1 tab via peg tube two times a day,b. simvastatin (to lower bad cholesterol) 10 mg 2 tablets by mouth at bedtime,c. dorzolamide hydrochloride-timolol opthalmic solution (reduce pressure in the eye) 1 drop in each eye,d. levothyroxine (to treat underactive thyroid) 100 micrograms 1 tab via peg tube one time a day, e. clopidogrel bisufate (antiplatelet- to prevent blood clots) 75 mg 1 tab via peg tube one time a day, f. furosemide (diuretic) 20 mg 1 tab by mouth one time a day, g. pantoprazole (decreases acid production in the stomach) 40 mg give 1 packet via peg-tube one time a day, and h. vitamin D3 (helps absorb calcium and supports immune system) 5000 units 1 tab by mouth one time a day.A June 2026 MAR for Resident #6 showed blank spots for the following dates:a. 06/19/26- memantine 7:00 p.m. dose; simvastatin evening dose; dorzolamide evening dose; pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, b. 06/20/26 - pantoprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, c. 06/21/26 - memantine 7:00 a.m. and 7:00 p.m. dose; simvastatin evening dose; dorzolamide 7:00 a.m. and evening dose; levothyroxine 7:00 am dose, clopidogrel 7:00 a.m. dose, furosemide 7:00 a.m. dose, pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, d. 06/22/26 - pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, e. 06/23/26 - memantine 7:00 p.m. dose; simvastatin evening dose; dorzolamide evening dose; pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, f. 06/24/26 - pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose, and g. 06/25/26 - pantaprazole 7:00 a.m. dose; vitamin D3 7:00 a.m. dose. On 06/25/26 at 12:12 p.m., the DON stated they has asked RN #1 why there were so many blank (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spaces on Resident 6's medication administration record. The DON stated RN #1 stated they had administered the medication, but just did not have time to chart they were administered. On 06/25/26 at 2:40 p.m., LPN #2 found the box of pantaprazole packets in the medication cart after calling the pharmacy to find out the pantaprazole packets were delivered on 06/18/26. LPN #2 counted the packets and found all 30 were still accounted for. On 06/25/26 at 4:00 p.m., the DON acknowledged the pantaprazole was probably not given if none of the packets were missing from the box.