

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 01/30/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35389</p> <p>Based on observation, record review, and interview, the facility failed to report to the SA:</p> <p>a. an allegation of abuse for one (#9); and</p> <p>b. an injury of unknown origin for one (#11) of four sampled residents reviewed for reportable incidents.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse Prevention Program policy, dated 10/22/22, read in parts, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property .Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator .The Administrator is the Abuse Coordinator .IF YOU SUSPECT ABUSE .Notify a Supervisor/Nurse Immediately .Notify the Administrator and Director of Nursing .The Administrator or designee utilizing the state specific Incident Reporting System will immediately notify the Department of Health by the Incident Reporting System .Investigation .All incidents will be documented, whether or not abuse occurred, was alleged or suspected .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .All personnel must promptly report any incident or suspected incident of abuse, mistreatment or neglect, including injuries of unknown origin. (An injury should be classified as an Injury of unknown origin when the source of the injury was not observed or known by any person, and the initial Risk Management investigation could not determine the cause of the injury).</p> <p>1. Resident #9 had diagnoses which included cognitive communication deficit and generalized anxiety.</p> <p>An Admission Assessment, dated 11/06/24, documented Resident #9 was cognitively intact, but was dependent on staff for bathing, lower body dressing, and toileting hygiene. It documented Resident #9 required moderate assistance with bed mobility, transfers, and upper body dressing. It documented walking did not occur.</p> <p>(continued on next page)</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/28/25 at 11:55 a.m., the administrator stated Resident #9 was confused. The administrator then stated they had a representative from the state come out in January to investigate an allegation of someone slamming Resident #9 against the bed. The administrator stated once the representative completed their investigation, they told the administrator to hold off on the state reportable.</p> <p>On 01/28/25 at 12:12 p.m., the ADON stated they knew Resident #9 had reported a situation about two weeks ago because Adult Protective Services came to the facility to investigate.</p> <p>On 01/28/25 at 4:20 p.m., the administrator provided their written statement, dated 01/15/25, which read in part, At about 1:13 p.m., a representative from the state [name withheld] came by the facility. [They] mentioned that a case was called in for [Resident #9] that someone pushed [them] against the bed. The representative then asked is there a staff [CNA #3] that works here? I said yes. [They] proceeded to speak with the resident. I called staff [CNA #3] to write me a statement and I was ready to suspend [them] pending investigations. [APS representative] told me to wait as [they] would like to finish [their] investigations first. [They] met with the resident and staff. [Their] conclusion for exit was with me, the DON and the staff. [They] told us not to report anything and that if [they] needed any additional information, [they] would let us know. I clarified if it was reportable. [They] said no and left the facility. Myself and the ADON went to meet with the resident and [Resident #9] could not recall any incident and [they] felt safe in the facility. The document was signed by the administrator.</p> <p>The administrator provided a written statement, dated 1/15/25, which was signed by CNA #3. It read in part, On the 15th a state [representative] came and asked me a few questions. I did not really know what [they] were talking about. [They] said that [Resident #9] was confused and did not remember anything and that everything is good after [they] did the investigation.</p> <p>On 01/28/25 at 4:25 p.m., Resident #9's POA stated the only allegation they were aware of was that a CNA had thrown their hands up and stated they were not going to do that again referring to cleaning up Resident #9's diarrhea. The POA stated they had talked to the DON about that allegation. The POA stated Resident #9 had a hard time processing and had confusion. The POA stated in the past when Resident #9 had a UTI, the POA would get calls from Resident #9 that someone was trying to break into the hospital. The POA stated they were at the facility about every two days and had not heard any new allegations.</p> <p>There was no incident report for the allegation that was investigated by Adult Protective Services on 01/15/25. There was no mention of any of the allegations in any of the progress notes. The only documentation of that incident was the written statement by the administrator and CNA #3.</p> <p>2. Resident #11 had diagnoses which included stage three chronic kidney disease and dementia.</p> <p>An Annual Resident Assessment, dated 11/29/24, documented Resident #11 had severe cognitive impairment and required substantial/maximal assistance for toilet hygiene, upper body dressing, lower body dressing, personal hygiene, rolling to left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. It documented the task of walk ten feet did not occur.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Nurse's Note, dated 12/27/24, documented Resident #11 was noted with purple discoloration under the left breast/ribs and left upper and forearm. It documented the ADON, administrator, and NP were notified. It documented orders were obtained for a stat x-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the discoloration and new order. There was no origin of the bruising identified in the nurse note. The note was signed by LPN #1.</p> <p>An Incident Report, dated 12/27/24, documented Resident #11 was noted with purple discoloration under their left breast/ribs and left upper and forearm. It documented the resident was unable to give a description. It documented the ADON, Administrator, and NP were notified and new orders were received for stat x-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the new order and discoloration. It documented injuries observed at time of incident: bruise left forearm, bruise left upper arm, bruise other describe (nothing was described in this section). The notes section documented discoloration to left upper and lower arm, left breast, and left side. It documented no injuries were observed post incident. It read in part, No statements found. There was no origin of the bruising identified in the incident report.</p> <p>A Nurse's Note, dated 12/30/24, documented continue focused charting related to left upper extremity, side, and breast. It documented no worsening discoloration noted. It documented no new injuries noted. It documented the resident did show signs and symptoms of pain and prn pain medication was administered in the morning and was effective. It documented continue to use a full body lift with transfer, mobile by wheelchair pushed by staff. It documented Resident #11 would at times self propel with their feet. It documented staff were to anticipate needs and assist with all transfers and ADLs.</p> <p>There was no documentation the injury of unknown origin was reported to the SA.</p> <p>On 01/28/25 at 10:29 a.m., an phone call was placed to family member #1. The family member did not answer the call and did not return the call.</p> <p>On 01/29/25 from 10:29 a.m. through 10:36 a.m., LPN #1 and ACMA #1 were observed providing incontinent care to Resident #11 and transferred the resident to a wheelchair using a full body mechanical lift. There were no bruises observed on the resident's skin.</p> <p>On 01/29/25 at 10:43 a.m., ACMA #1 stated Resident #11 used to use the sit to stand lift, but did not anymore. ACMA #1 stated staff had to turn the resident in bed and was a total assist for transfers, dressing, toileting and bathing.</p> <p>On 01/29/25 at 10:47 a.m., ACMA #1 stated they just recently started using the total body lift on Resident #11.</p> <p>On 01/29/25 at 10:49 a.m., ACMA #1 stated they were not aware of any incidents involving Resident #11 in the last two months.</p> <p>On 01/29/25 at 10:51 a.m., CNA #3 stated Resident #11 was a total body lift for transfers. They stated staff had to do everything for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/29/25 at 10:54 a.m., CNA #3 stated they had been using the full body lift on Resident #11 for about a month. CNA #3 stated Resident #11 had experienced bruising. CNA #3 they stated they did not know who first observed the bruising, but the facility started to use a full body lift.</p> <p>On 01/29/25 at 11:31 a.m., LPN #1 reviewed the nurse's note for Resident #11 dated 12/27/24, and stated the CNAs had come to LPN #1 and reported some discoloration. LPN #1 stated they went and looked at Resident #11's skin and their left side, upper arm down to the lower arm, ribs and under breast were involved. LPN #1 stated they notified the ADON, administrator, and NP who gave orders for the x-rays. LPN #1 stated they also notified the family. LPN #1 stated the x-rays did not show injuries, but the facility changed from using the sit to stand lift to the full body lift. LPN #1 stated anytime they identified new bruising on a resident, they would view the skin themselves, notify the provider, and notify the abuse coordinator who was the administrator so they could investigate.</p> <p>On 01/29/25 at 11:39 a.m., LPN #1 was asked if the facility had identified the origin of the bruising. LPN #1 stated, Let me go ask the people who did the investigation.</p> <p>On 01/29/25 at 11:42 a.m., LPN #1 returned and stated the administrator was who completed the investigation. LPN #1 did not provide the origin of the bruising.</p> <p>On 01/29/25 at 12:49 p.m., the administrator was asked for all information related to the incident on 12/27/24 involving Resident #11.</p> <p>On 01/29/25 at 1:07 p.m., CNA #3 stated if they observed abuse or neglect, or it was reported to them, they would notify the nurse.</p> <p>On 01/29/25 at 1:14 p.m., LPN #1 stated if they observed abuse or neglect they would notify the abuse coordinator, the physician, and the resident's responsible party.</p> <p>On 01/29/25 at 1:15 p.m., LPN #1 stated the types of abuse they observed for were physical, mental, emotional, isolation, seclusion, and sexual abuse.</p> <p>On 01/29/25 at 2:01 p.m., the administrator was asked again if they had any additional information related to the incident involving Resident #11. The administrator stated it was in their office. The surveyor followed the administrator to their office. The administrator stated they had completed interviews with staff and was still waiting for them to be scanned in. The administrator stated, I didn't do a Reportable though. The administrator stated, I just did staff interviews.</p> <p>On 01/29/25 at 2:03 p.m., the administrator was asked to identify what they considered to be abuse or neglect. The administrator stated, Whether it's factual or not, if you have a reportable, or if you have an incident you are unsure of, you report it. The administrator stated, Whether it's physical, verbal, emotional, misappropriation of funds, if there is any injury like an unknown injury, we report that. The administrator stated what qualified as unknown was, If after your investigation that you have that it happened, while you are investigating, if you still can't find the reason that it happened, of course we report it.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/29/25 at 2:05 p.m., the administrator stated when an incident was reported to them, they started an investigation. They stated they would write out statements from everybody. They stated if it was on the hall, they would get statements from whomever was involved. The administrator stated they report it if it was something unusual. The administrator stated, If it's something that needs to go to the State, I report it to the State if we cannot find out what happened, and then report it.</p> <p>On 01/29/25 at 2:07 p.m., the administrator stated abuse was to be reported within two hours and an injury of unknown origin had to be reported.</p> <p>On 01/29/25 at 2:08 p.m., the administrator stated they were notified Resident #11 had a bruise, so they went down and looked at the resident. The administrator stated the bruising was to the left arm, ribs, left side, and breast area. The administrator stated the CNA was giving the resident a bed bath and that was when it was reported to the administrator. The administrator stated they spoke with the nurse who reported the CNA had reported it to them, the doctor was called, and a x-ray was ordered.</p> <p>On 01/29/25 at 2:10 p.m., the administrator stated they asked CNA #5 about the bruising and the CNA stated the bruising was not there the day before. The administrator stated they pulled the shower sheets and the bruising definitely was not there. The administrator stated the only thing they could think of that caused the bruising was the sit to stand lift. The administrator stated they completed an inservice the same day for the sit to stand lift. The administrator stated they changed Resident #11 from a sit to stand lift to a full body lift.</p> <p>On 01/29/25 at 2:14 p.m., the therapy program manager arrived and stated they had evaluated the resident for suspicious bruising.</p> <p>On 01/29/25 at 2:17 p.m., the therapy program manager stated Resident #11 had very decreased cognition and increased muscle resistance. They stated it was heavily recommended for the resident to be a full body lift for safety. The therapy program manager stated from what they understood about the suspicious bruising, was that it was related to bed mobility.</p> <p>On 01/29/25 at 2:19 p.m., the therapy program manager stated they were never told about a concern with the sit to stand and therapy did not evaluate Resident #11 for a sit to stand.</p> <p>On 01/29/25 at 2:20 p.m., the administrator stated an injury was unknown if they could not find the reason. The administrator stated they knew it was the equipment because staff stated they had informed the nurse several days about pain with transfers.</p> <p>On 01/29/25 at 2:22 p.m., the administrator was asked if that information was documented anywhere. They stated, I don't see anything on here for that.</p> <p>On 01/29/25 at 2:26 p.m., the administrator was asked if the facility determined the origin of the bruising. The administrator stated, From the sit to stand. They were asked how they determined that. The administrator stated, Because the CNA told me. They stated based on the two CNA statements on the hall.</p> <p>On 01/29/25 at 2:44 p.m., after filtering through a stack of papers on the desk, the administrator stated they had found the interviews and provided the following forms:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. a Resident Interview form for Resident #11. It read in part, Use as part of an Abuse investigation. There was no date on the form and the interviewer section was blank;</p> <p>b. a Confidential Witness Statement, dated 12/27/24, signed by CNA #5 and the administrator, read in part, I was about to give a bed bath, I notified a bruise to [their] left breast, ribs, upper arm forearm. I went to go get the nurse. I took care of [them] the day before and the bruise was not there. However [they] did complain it hurts during transfer with the sit-to-stand.;</p> <p>c. a Confidential Witness Statement, dated 12/27/24, signed by LPN #1 and the administrator, read in part, I was notified by the CNA that there was a bruise to [left] arm and rib cage. I went to do an assessment. I called the NP, family and [unknown] order for X-ray. This bruise was not there the day prior.; and</p> <p>d. a Confidential Witness Statement, dated 12/27/24, signed by CNA #2 and the administrator, read in part, I observed that the sit to stand equipment hurts [Resident #11] arms when we tried to transfer. I notified the nurse. I was unaware of the bruise.</p> <p>The administrator stated they had interviewed Resident #11 the day of the incident. The administrator was asked to explain use as part of an abuse investigation on the interview form. The administrator stated they had ruled out abuse because after the interview, they determined it was the equipment that caused it.</p> <p>On 01/29/25 at 2:48 p.m., the administrator was asked where they documented they had identified the cause of the bruise in their investigation. The administrator stated, From what staff told me. The administrator stated they reviewed the record and the resident had no incident and no fall. The administrator was shown the incident report, dated 12/27/25, for Resident #11 and was asked if they had anything that documented the findings of their investigation. The administrator was unable to locate this documentation for the surveyor at the time.</p> <p>On 01/30/25 at 8:32 a.m., CNA #2 stated the day the incident occurred 12/27/24 with Resdient #11, they went to help CNA #5. CNA #2 stated the resident was laying in bed and when they removed Resident #11's clothes we noticed bruising all over [them]. CNA #2 stated the nurse was notified at the time. CNA #2 sated they did not know where the bruising came from.</p> <p>On 01/30/25 at 8:50 a.m., CNA #5 stated on 12/27/24 they walked into Resident #11's room to give them a bed bath with CNA #2. CNA #5 stated the resident was still in bed. CNA #5 stated as they removed the resident's clothes they observed a bruise to their back and breast area. CNA #5 stated they were to get the nurse who examined the resident. CNA #5 stated they did not know where the bruising came from.</p> <p>49701</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>35389</p> <p>Based on observation, record review and interview, the facility failed to fully investigate:</p> <p>a. an allegation of abuse for one (#9); and</p> <p>b. an injury of unknown origin for one (#11) of four sampled residents reviewed for reportable incidents.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse Prevention Program, policy, dated 10/22/22, read in part, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property .Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator .The Administrator is the Abuse Coordinator .IF YOU SUSPECT ABUSE .Notify a Supervisor/Nurse Immediately .Notify the Administrator and Director of Nursing .The Administrator or designee utilizing the state specific Incident Reporting System will immediately notify the Department of Health by the Incident Reporting System .Investigation .All incidents will be documented, whether or not abuse occurred, was alleged or suspected .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .All personnel must promptly report any incident or suspected incident of abuse, mistreatment or neglect, including injuries of unknown origin. (An injury should be classified as an Injury of unknown origin when the source of the injury was not observed or known by any person, and the initial Risk Management investigation could not determine the cause of the injury).</p> <p>1. Resident #9 had diagnoses which included cognitive communication deficit and generalized anxiety.</p> <p>An Admission Assessment, dated 11/06/24, documented Resident #9 was cognitively intact, but was dependent on staff for bathing, lower body dressing, and toileting hygiene. It documented Resident #9 required moderate assistance with bed mobility, transfers, and upper body dressing. It documented walking did not occur.</p> <p>On 01/27/25 at 12:58 p.m., Resident #9 stated one of the weekend CMAs threw pills at them and used curse words. Resident #9 stated they reported the incident to the weekend charge nurse.</p> <p>On 01/28/25 at 11:55 a.m., the administrator stated Resident #9 was confused. The administrator then stated they had a representative from the state come out in January to investigate an allegation of someone slamming Resident #9 against the bed. The administrator stated once the representative completed their investigation they told the administrator to hold off on the state reportable.</p> <p>On 01/28/25 at 12:04 p.m., the DON stated they had not been made aware of any allegations that were about this past weekend. They stated they had been gone the past three weeks and had only returned last week. The DON stated anything during that time would have went through the administrator.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/28/25 at 12:12 p.m., the ADON stated they were on call this weekend and were not called for any abuse allegations over the weekend. The ADON stated they knew Resident #9 had reported a situation about two weeks ago because Adult Protective Services came to the facility to investigate.</p> <p>On 01/28/25 at 12:19 p.m., CMA #2 stated they were the CMA for hall 200 this past Sunday. CMA #2 stated they were unaware of Resident #9 making allegations against staff this past weekend.</p> <p>On 01/28/25 at 4:20 p.m., the administrator provided their written statement, dated 01/15/25, which read in part, At about 1:13 p.m., a representative from the state [name withheld] came by the facility. [They] mentioned that a case was called in for [Resident #9] that someone pushed [them] against the bed. The representative then asked is there a staff [CNA #3] that works here? I said yes. [They] proceeded to speak with the resident. I called staff [CNA #3] to write me a statement and I was ready to suspend [them] pending investigations. [APS representative] told me to wait as [they] would like to finish [their] investigations first. [They] met with the resident and staff. [Their] conclusion for exit was with me, the DON and the staff. [They] told us not to report anything and that if [they] needed any additional information, [they] would let us know. I clarified if it was reportable. [They] said no and left the facility. Myself and the ADON went to meet with the resident and [Resident #9] could not recall any incident and [they] felt safe in the facility. The document was signed by the administrator.</p> <p>The administrator provided a written statement, dated 01/15/25, that was signed by CNA #3. It read in part, On the 15th a state [representative] came and asked me a few questions. I did not really know what [they] were talking about. [They] said that [Resident #9] was confused and did not remember anything and that everything is good after [they] did the investigation.</p> <p>On 01/28/25 at 4:25 p.m., Resident #9's POA stated the only allegation they were aware of was that a CNA had thrown their hands up and stated they were not going to do that again referring to cleaning up Resident #9's diarrhea. The POA stated they had talked to the DON about that allegation. The POA stated Resident #9 had a hard time processing and had confusion. The POA stated in the past when Resident #9 had a UTI, the POA would get calls from Resident #9 that someone was trying to break into the hospital. The POA stated they were at the facility about every two days and had not heard any new allegations.</p> <p>There was no incident report for the allegation that was investigated by Adult Protective Services on 01/15/25. There was no mention of any of the allegations in any of the progress notes. The only documentation of that incident was the written statement by the administrator and CNA #3</p> <p>2. Resident #11 had diagnoses which included stage three chronic kidney disease and dementia.</p> <p>An Annual Resident Assessment, dated 11/29/24, documented Resident #11 had severe cognitive impairment and required substantial/maximal assistance for toilet hygiene, upper body dressing, lower body dressing, personal hygiene, rolling to left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. It documented the task of walk ten feet did not occur.</p> <p>(continued on next page)</p>		

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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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Nurse's Note, dated 12/27/24, documented Resident #11 was noted with purple discoloration under the left breast/ribs and left upper and forearm. It documented the ADON, administrator, and NP were notified. It documented orders were obtained for a stat x-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the discoloration and new order. There was no origin of the bruising identified in the nurse note. The note was signed by LPN #1.</p> <p>An Incident Report, dated 12/27/24, documented Resident #11 was noted with purple discoloration under their left breast/ribs and left upper and forearm. It documented the resident was unable to give a description. It documented the ADON, administrator, and NP were notified and new orders were received for stat x-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the new order and discoloration. It documented injuries observed at time of incident: bruise left forearm, bruise left upper arm, bruise other describe (nothing was described in this section). The notes section documented discoloration to left upper and lower arm, left breast, and left side. It documented no injuries were observed post incident. It read in part, No statements found. There was no origin of the bruising identified in the incident report.</p> <p>A Nurse's Note, dated 12/30/24, documented continue focused charting related to left upper extremity, side, and breast. It documented no worsening discoloration noted. It documented no new injuries noted. It documented the resident did show signs and symptoms of pain and PRN pain medication was administered in the morning and was effective. It documented continue to use a full body lift with transfer, mobile by wheelchair pushed by staff. It documented Resident #11 would at times self propel with their feet. It documented staff were to anticipate needs and assist with all transfers and adls.</p> <p>There was no documentation the injury of unknown origin was reported to the SA.</p> <p>A Physician Order, late entry date 01/03/25, read in part, PT Clarification Order to eval only for suspicious bruising and d/c from PT services upon completion of eval.</p> <p>On 01/28/25 at 10:29 a.m., a phone call was placed to family member #1. The family member did not answer the call and did not return the call.</p> <p>On 01/29/25 from 10:29 a.m. through 10:36 a.m., LPN #1 and ACMA #1 were observed providing incontinent care to Resident #11 and transferred the resident to a wheelchair using a full body mechanical lift. There were no bruises observed on the resident's skin.</p> <p>On 01/29/25 at 10:43 a.m., ACMA #1 stated Resident #11 used to use the sit to stand lift, but did not anymore. ACMA #1 stated staff had to turn the resident in bed and was a total assist for transfers, dressing, toileting, and bathing.</p> <p>On 01/29/25 at 10:47 a.m., ACMA #1 stated they just recently started using the total body lift on Resident #11.</p> <p>On 01/29/25 at 10:49 a.m., ACMA #1 stated they were not aware of any incidents involving Resident #11 in the last two months.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/29/25 at 10:51 a.m., CNA #3 stated Resident #11 was a total body lift for transfers. They stated staff had to do everything for the resident.</p> <p>On 01/29/25 at 10:54 a.m., CNA #3 stated they had been using the full body lift on Resident #11 for about a month. CNA #3 stated Resident #11 had experienced bruising. They stated they did not know who first observed the bruising, but the facility started to use a full body lift.</p> <p>On 01/29/25 at 11:31 a.m., LPN #1 reviewed the nurse's note for Resident #11, dated 12/27/24, and stated the CNAs had come to LPN #1 and reported some discoloration. LPN #1 stated they went and looked at Resident #11's skin and their left side, upper arm down to the lower arm, ribs and under breast were involved. LPN #1 stated they notified the ADON, administrator, and NP who gave orders for the x-rays. LPN #1 stated they also notified the family. LPN #1 stated the x-rays did not show injuries, but the facility changed from using the sit to stand lift to the full body lift. LPN #1 stated anytime they identified new bruising on a resident they would view the skin themselves, notify the provider, and notify the abuse coordinator who was the administrator so they could investigate.</p> <p>On 01/29/25 at 11:35 a.m., LPN #1 stated therapy had evaluated the resident after the bruising and they thought that was where the full body lift came from.</p> <p>On 01/29/25 at 11:39 a.m., LPN #1 was asked if the facility had identified the origin of the bruising. LPN #1 stated, Let me go ask the people who did the investigation.</p> <p>On 01/29/25 at 11:42 a.m., LPN #1 returned and stated the administrator was who completed the investigation. LPN #1 did not provide the origin of the bruising.</p> <p>On 01/29/25 at 12:49 p.m., the administrator was asked for all information related to the incident on 12/27/24 involving Resident #11.</p> <p>On 01/29/25 at 1:07 p.m., CNA #3 stated if they observed abuse or neglect, or it was reported to them, they would notify the nurse.</p> <p>On 01/29/25 at 1:14 p.m., LPN #1 stated if they observed abuse or neglect they would notify the abuse coordinator, the physician, and the resident's responsible party.</p> <p>On 01/29/25 at 1:15 p.m., LPN #1 stated the types of abuse they observed for were physical, mental, emotional, isolation, seclusion, and sexual abuse.</p> <p>On 01/29/25 at 2:01 p.m., the administrator was asked again if they had any additional information related to the incident involving Resident #11. The administrator stated it was in their office. The surveyor followed the administrator to their office. The administrator stated they had completed interviews with staff and was still waiting for them to be scanned in. The administrator stated, I didn't do a Reportable though. The administrator stated, I just did staff interviews.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/29/25 at 2:03 p.m., the administrator was asked to identify what they considered to be abuse or neglect. The administrator stated, Whether it's factual or not, if you have a reportable, or if you have an incident you are unsure of, you report it. The administrator stated, Whether it's physical, verbal, emotional, misappropriation of funds, if there is any injury like an unknown injury, we report that. The administrator stated what qualified as unknown was, If after your investigation that you have that it happened, while you are investigating, if you still can't find the reason that it happened, of course we report it.</p> <p>On 01/29/25 at 2:05 p.m., the administrator stated when an incident was reported to them, they started an investigation. They stated they would write out statements from everybody. They stated if it was on the hall, they would get statements from whomever was involved. The administrator stated they report it if it was something unusual. The administrator stated, If it's something that needs to go to the State, I report it to the State if we cannot find out what happened, and then report it.</p> <p>On 01/29/25 at 2:07 p.m., the administrator stated abuse was to be reported within two hours, and an injury of unknown origin had to be reported.</p> <p>On 01/29/25 at 2:08 p.m., the administrator stated they were notified Resident #11 had a bruise, so they went down and looked at the resident. The administrator stated the bruising was to the left arm, ribs, left side, and breast area. The administrator stated the CNA was giving the resident a bed bath and that was when it was reported to the administrator. The administrator stated they spoke with the nurse who reported the CNA had reported it to them, the doctor was called, and an x-ray was ordered.</p> <p>On 01/29/25 at 2:10 p.m., the Administrator stated they asked CNA #5 about the bruising and the CNA stated the bruising was not there the day before. The administrator stated they pulled the shower sheets and the bruising definitely was not there. The administrator stated the only thing they could think of that caused the bruising was the sit to stand lift. The administrator stated they completed an inservice the same day for the sit to stand lift. The administrator stated they changed Resident #11 from a sit to stand lift to a full body lift. The administrator stated they had instructed the ADON to have therapy evaluate the resident for transfer skills.</p> <p>On 01/29/25 at 2:14 p.m., the therapy program manager arrived and stated they had evaluated the resident for suspicious bruising.</p> <p>On 01/29/25 at 2:15 p.m., the administrator was asked where all the interviews were at. They stated the medical records staff resigned and they needed to look through a stack of papers.</p> <p>On 01/29/25 at 2:17 p.m., the therapy program manager stated Resident #11 had very decreased cognition and increased muscle resistance. They stated it was heavily recommended for the resident to be a full body lift for safety. The therapy program manager stated from what they understood about the suspicious bruising, was that it was related to bed mobility.</p> <p>On 01/29/25 at 2:19 p.m., the therapy program manager stated they were never told about a concern with the sit to stand, and therapy did not evaluate Resident #11 for a sit to stand.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/29/25 at 2:20 p.m., the administrator stated an injury was unknown if they could not find the reason. The administrator stated they knew it was the equipment because staff stated they had informed the nurse several days about pain with transfers.</p> <p>On 01/29/25 at 2:22 p.m., the administrator was asked if that information was documented anywhere. They stated, I don't see anything on here for that.</p> <p>On 01/29/25 at 2:23 p.m., the administrator was asked what the Initial Risk Management was. They stated, It will be everything that I write.</p> <p>On 01/29/25 at 2:25 p.m., the administrator was asked where the information was located. They stated they were looking through a stack of papers.</p> <p>On 01/29/25 at 2:26 p.m., the administrator was asked if the facility determined the origin of the bruising. The administrator stated, From the sit to stand. They were asked how they determined that. The administrator stated, Because the CNA told me. They stated based on the two CNA statements on the hall.</p> <p>On 01/29/25 at 2:28 p.m., the administrator had the ADON join the interview. The ADON stated the facility completed an inservice about safety and utilizing two people for a full mechanical lift as well as the proper use of a sit to stand lift. The ADON stated x-rays were obtained and they spoke with therapy to complete an eval. The ADON stated Resident #11 was changed to a full body lift that day, but nothing else form us.</p> <p>On 01/29/25 at 2:31 p.m., the administrator asked the ADON about the shower sheets to verify there was no bruising on Resident #11 the day before. The ADON did not respond.</p> <p>On 01/29/25 at 2:34 p.m., the administrator was asked where the interviews for the investigation were located. The administrator walked to another office then returned to their office.</p> <p>On 01/29/25 at 2:44 p.m., the DON provided a sign in sheet for a full body transfer lift and sit to stand transfer inservice dated 12/27/24. There was no additional information related to this inservice provided to the survey team prior to exit. After filtering through a stack of papers on the desk, the administrator stated they had found the interviews and provided the following forms:</p> <p>a. a Resident Interview form for Resident #11. It read in part, Use as part of an Abuse investigation. There was no date on the form and the interviewer section was blank;</p> <p>b. a Confidential Witness Statement, dated 12/27/24, signed by CNA #5 and the administrator, read in part, I was about to give a bed bath, I notified a bruise to [their] left breast, ribs, upper arm forearm. I went to go get the nurse. I took care of her the day before and the bruise was not there. However [they] did complain it hurts during transfer with the sit-to-stand.;</p> <p>c. a Confidential Witness Statement, dated 12/27/24, signed by LPN #1 and the administrator, read in part, I was notified by the CNA that there was a bruise to [left] arm and rib cage. I went to do an assessment. I called the NP, family and [unknown] order for X-ray. This bruise was not there the day prior.; and</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. a Confidential Witness Statement, dated 12/27/24, signed by CNA #2 and the administrator, read in part, I observed that the sit to stand equipment hurts [Resident #11] arms when we tried to transfer. I notified the nurse. I was unaware of the bruise.</p> <p>The administrator stated they had interviewed Resident #11 the day of the incident. The administrator was asked to explain use as part of an abuse investigation on the interview form. The administrator stated they had ruled out abuse because after the interview, they determined it was the equipment that caused it.</p> <p>On 01/29/25 at 2:48 p.m., the administrator was asked where they documented they had identified the cause of the bruise in their investigation. The administrator stated, From what staff told me. The administrator stated they reviewed the record and the resident had no incident and no fall. The administrator was shown the incident report dated 12/27/25 for Resident #11 and was asked if they had anything that documented the findings of their investigation. The administrator was unable to locate this documentation at the time.</p> <p>On 01/29/25 at 2:58 p.m., LPN #2 stated they were made aware the administrator had the staff fill out the forms related to the bruising on Resident #11 today. LPN #2 stated they did not want staff getting in trouble for the administrator completing interviews after the fact when the investigation should have been done.</p> <p>On 01/30/25 at 8:21 a.m., LPN #1 was asked to explain the confidential witness statement, dated 12/27/24, signed by them.</p> <p>On 01/30/25 at 8:23 a.m., LPN #1 stated the had went over what happened with the administrator yesterday. LPN #1 stated, I did not want to sign the form. They stated, It was yesterday. LPN #1 stated, I feel I should not have been put in that position. LPN #1 stated, I was told to sign it by The administrator. LPN #1 stated no one had asked LPN #1 about any statements prior to yesterday. LPN #1 stated everything was in their nurse's notes. LPN #1 stated they made sure the x-ray order was in for the bruising. They stated they told the ADON and administrator and contacted the doctor. LPN #1 stated there was an inservice the following week regarding the lifts.</p> <p>On 01/30/25 at 8:28 a.m., CNA #2 stated the administrator had filled out the confidential witness statement and had me sign it. They stated it was completed yesterday. CNA #2 stated, It bothered me all day yesterday. They stated, I couldn't sleep. CNA #2 stated, [They] made it like we would be in some sort of trouble if we didn't sign it. CNA #2 stated it was filled out yesterday by the administrator who instructed CNA #2 to put the 12/27/24 date. CNA #2 stated they questioned the administrator about the date and the administrator informed them State would come and talk to them and instructed CNA #2 to tell them the date on the form. CNA #2 stated when the incident occurred, they told them about it.</p> <p>On 01/30/25 at 8:32 a.m., CNA #2 stated the day the incident occurred 12/27/24 with Resdient #11, they went to help CNA #5. CNA #2 stated the resident was laying in bed and when they removed Resident #11's clothes we noticed bruising all over [them]. CNA #2 stated the nurse was notified at the time. CNA #2 sated they did not know where the bruising came from.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/30/25 at 8:47 a.m., CNA #5 stated the administrator had written out the entire witness statement. CNA #5 stated they did not know anything about the statement until the administrator called them into the office yesterday. CNA #5 stated they had reported the bruising to the nurse the day it occurred. They stated yesterday the administrator told them I'm going to write this statement, I'm going to need you to sign it. CNA #5 stated the administrator stated if anyone asked, they were to say it was already documented. CNA #5 stated they did not feel good about it because it was forging something and they didn't want to get in trouble. CNA #5 stated the administrator instructed, You sign it but, I'm going to write it. CNA #5 stated, I didn't want to sign it because it wasn't in my handwriting and this wasn't my report. CNA #5 stated it was weeks ago and they should have already had it together.</p> <p>On 01/30/25 at 8:50 a.m., CNA #5 stated on 12/27/24 they walked into Resident #11's room to give them a bed bath with CNA #2. CNA #5 stated the resident was still in bed. CNA #5 stated as they removed the resident's clothes, they observed a bruise to their back and breast area. CNA #5 stated they were to get the nurse who examined the resident. CNA #5 stated they did not know where the bruising came from. They stated they received an inservice on lifts on a Tuesday because they always received inservices on paydays (12/27/24 was a Friday). They stated they could not remember the exact date of the inservice.</p> <p>49701</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure a significant change resident assessment was completed when a resident was placed on hospice services for one (#43) of two sampled residents reviewed for hospice services.</p> <p>The DON identified three hospice residents resided in the facility.</p> <p>Findings:</p> <p>A Guidelines for Assessments policy, dated 05/29/24, read in part, It is the policy of the facility to ensure that assessments of the residents take place timely, at the appropriate time and are accurate.</p> <p>Resident #43 had diagnoses which included dementia, generalized anxiety disorder, and atherosclerotic heart disease of native coronary artery.</p> <p>A Physician Order, dated 10/30/25, documented admit to hospice care services for diagnosis of senile degenerate.</p> <p>There was no significant change resident assessment completed when the resident began hospice services in Resident #43's clinical record.</p> <p>On 01/29/25 at 1:07 p.m., CNA #3 stated Resident #43 was receiving hospice services.</p> <p>On 01/29/25 at 1:13 p.m., LPN #2 stated Resident #43 was receiving hospice services and they started a couple months ago.</p> <p>On 01/29/25 at 1:26 p.m., the DON stated regional staff were completing resident assessments and they would try to get hold of someone.</p> <p>On 01/29/25 at 1:45 p.m., the MDS consultant was identified by the DON as being able to answer resident assessment questions. The DON called them on speaker phone and remained in the room.</p> <p>On 01/29/25 at 1:46 p.m., the MDS consultant stated a significant change resident assessment was completed when a resident had two areas of decline or improvement that required care plan revision due to a change in their baseline. The MDS consultant stated a significant change resident assessment was to be completed when a resident went on hospice services.</p> <p>On 01/29/25 at 1:49 p.m., the MDS consultant stated the resident was receiving hospice services as of 10/30/24 and a significant change should have been completed.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure resident assessment were accurately coded for four (#10, 21, 43, and #54) 17 sampled residents reviewed for resident assessments.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>A Guidelines for Assessments policy, dated 05/29/24, read in part, It is the policy of the facility to ensure that assessments of the residents take place timely, at the appropriate time and are accurate.</p> <p>1. Resident #10 had diagnoses which included Alzheimer's.</p> <p>A Care Plan, dated 07/20/23, documented Resident #10 was at risk for elopement due to wandering and verbalizing wanting to leave the facility.</p> <p>A Wound Care Specialist Progress Note, dated 10/23/24, documented Resident #10 had a stage 3 pressure ulcer to left heel and a stage 4 pressure ulcer to sacrum.</p> <p>Resident #10's Quarterly Resident Assessment, dated 11/13/24, documented not applicable for walking 50 feet or more. It also documented they had one stage 3 pressure ulcer, but no other pressure ulcers.</p> <p>On 01/29/25 at 12:19 p.m., the DON stated Resident #10 was constantly walking around the facility. They were unable to find documentation the stage 4 of the sacrum had healed. They stated the assessment was coded incorrectly.</p> <p>2. Resident #21 admitted with a diagnosis of chronic pain.</p> <p>A physician's order, dated 11/07/23, documented oxycodone HCl (a narcotic) 10mg q 6hrs as needed for pain.</p> <p>The January 2025 TAR documented the resident was administered PRN pain medication daily from 01/02/25 through 01/08/25.</p> <p>A quarterly assessment, dated 01/08/25, documented the resident did not take any PRN pain medication in the five day look back period.</p> <p>On 01/30/25 at 1:10 p.m. the regional MDS consultant was made aware the MDS documented the resident did not receive any PRN pain medication during the look back period and the TAR documented the resident received pain medication daily from 01/02/25 to 01/08/25. The regional MDS consultant reported the assessment was incorrect.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident #43 had diagnoses which included dementia, generalized anxiety disorder, and atherosclerotic heart disease of native coronary artery.</p> <p>A Physician Order, dated 10/30/24, documented to admit to hospice care services for diagnoses of senile degeneration.</p> <p>Resident #43's Quarterly Resident Assessment, dated 12/20/24, documented under the prognosis section, the life expectancy of less than six months was documented as no. The special treatments, procedures, and programs section did not document the resident received hospice care while a resident.</p> <p>On 01/29/25 at 1:07 p.m., CNA #3 stated Resident #43 was receiving hospice services.</p> <p>On 01/29/25 at 1:13 p.m., LPN #2 stated Resident #43 was receiving hospice services and they started a couple months ago.</p> <p>On 01/29/25 at 1:26 p.m. , the DON stated regional staff were completing resident assessments and they would try to get hold of someone.</p> <p>On 01/29/25 at 1:45 p.m., the MDS consultant was identified by the DON as being able to answer resident assessment questions. The DON called them on speaker phone and remained in the room. The MDS consultant stated they used the resident's medical record and an assessment of the resident in person which was a collaboration of the interdisciplinary team to complete resident assessments.</p> <p>On 01/29/25 at 1:46 p.m., the MDS consultant stated they ensured the assessments were accurately coded by making sure it aligned with the resident assessment instrument manual.</p> <p>On 01/29/25 at 1:48 p.m., the MDS consultant reviewed Resident #43's quarterly resident assessment, dated 12/20/24, and stated the prognosis life expectancy of less than six months was coded no. They stated it documented the resident did not receive hospice services under the special treatments, procedures, and programs section.</p> <p>On 01/29/25 at 1:49 p.m., the MDS consultant stated the resident was receiving hospice services as of 10/30/24 and the assessment was not accurately coded.</p> <p>4. Resident #54 admitted to the facility on skilled services with diagnoses of anxiety, depression, and fracture of right femur.</p> <p>A discharge summary, dated 11/23/24, documented the resident was discharged home.</p> <p>A discharge assessment, dated 11/23/24, documented the resident was discharged to the hospital.</p> <p>On 01/29/25 at 3:18 p.m., the DON reported the discharge assessment was coded wrong.</p> <p>43023</p> <p>49701</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>49701</p> <p>Based on observation, record review, and interview, the facility failed to prevent a decrease in range of motion for one (#51) of one sampled resident reviewed for decrease in range of motion.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #51 had diagnoses which included central cord syndrome of cervical spine paraplegia and muscle wasting.</p> <p>An Admission Assessment, dated 10/24/24, documented Resident #51 was cognitively intact, but had functional limitation in range of motion in both upper extremities.</p> <p>A Physician's Order, dated 10/28/24, documented right hand wrist contracture splint.</p> <p>A Physician's Order, dated 11/07/24, read in part, request adaptive equipment for eating: rocker knife, plate guard, and thick handled bent/curved silverware for left hand. Bedside commode for toilet training and to decrease assistance from care givers.</p> <p>On 01/30/25 at 9:49 a.m., the PTA stated while Resident #51 was on skilled they were able to walk using a specialized platform walker, but they could not let Resident #51 keep using it because it belonged to therapy. They PTA stated they had to use it for other residents. The PTA stated they did order one for Resident #51, but the specialized walker had still not arrived. The PTA stated they did not put Resident #51 on restorative because an insurance transition was supposed to be happening, and they were planning on picking Resident #51 up on part B services. The PTA stated the facility was supposed to provide the needed equipment, but they were not sure how that worked when residents were on private pay.</p> <p>On 01/30/25 at 9:57 a.m., the BOM stated it was not the therapy departments job to worry about insurance. The BOM stated therapy should order whatever needed to be ordered and they would worry about payment of services.</p> <p>On 01/30/25 at 10:04 a.m., the ADON stated they remembered the PTA having to remove the platform walker to take back to therapy. They stated adaptive equipment for eating had been ordered, but was not there yet. They were unsure about the splints having been ordered.</p> <p>On 01/30/25 at 10:19 a.m., the PTA stated they had ordered the bedside commode more than once, but they may not have put the platform walker order into the book for the physician to sign. They stated the wrist splint was ordered on 10/29/24, but had still not arrived.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/30/25 at 10:25 a.m., the dietary manager stated they had just got the order for the specialized adaptive equipment for eating. They stated the order was initiated 11/07/24. They stated they just now got the approval to order it and they instructed central supplies to put the order in on Monday 01/27/25.</p> <p>On 01/30/25 at 10:34 a.m., Resident #51 stated they had not had a bedside commode in their room since they had been in the facility. They also stated if they had the specialized platform walker they would be doing so much better. They stated when they were able to use one on skilled care they were able to stand up to be changed and cleaned. They stated they were unable to use their right hand due to the contracture and the utensils provided were very hard to use with their left hand.</p> <p>On 01/30/25 at 11:13 a.m., the PTA stated they found out today they should have taken a signed copy of the physician's order and given it to dietary, nursing, and the floor nurse. They stated they were still looking to see what happened to the order for the platform walker.</p> <p>On 01/30/25 at 11:45 a.m., the administrator stated they were putting in new procedures to make sure when therapy wrote orders, they gave them to all the departments involved to make sure the orders did not get missed.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to ensure a resident who received a psychotropic medication had an acceptable diagnosis/indication for the use of the medication for one (#9) of five sampled residents reviewed for unnecessary medications.</p> <p>The administrator identified 53 residents who resided in the facility.</p> <p>Findings:</p> <p>A Guidelines for Psychotropic Medication policy, dated 06/05/23, read in part, Based upon each individual resident's comprehensive assessment, the facility will ensure that residents who have not previously been on a psychotropic drug are not given these meds unless the medication is necessary to treat a specific condition/diagnosis, that is documented in the medical record by the physician.</p> <p>Resident #9 had diagnoses which included generalized anxiety disorder. There were no other psychiatric or mood disorder diagnoses.</p> <p>A physician's order, dated 10/31/24, documented the resident was to receive olanzapine (an antipsychotic) 5 mg two times a day.</p> <p>An Admission Assessment, dated 11/06/24, documented Resident #9 was cognitively intact with a BIMS score of 15. It documented Resident #9 was receiving an antipsychotic medication and not an antianxiety medication.</p> <p>A Progress Note completed by the APRN, dated 12/12/24, documented anxiety disorder. There were no other psychiatric or mood disorder diagnoses.</p> <p>A Progress Note completed by the medical doctor, dated 12/13/24, documented anxiety disorder. There were no other psychiatric or mood disorder diagnoses.</p> <p>On 01/29/25 at 12:13 p.m., the DON reviewed the resident's clinical record. The DON stated they only found general anxiety in the diagnoses list.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurate for one (#11) of four sampled residents reviewed for reportable incidents.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #11 had diagnoses which included stage three chronic kidney disease and dementia.</p> <p>A Nurse's Note, dated 12/27/24, documented Resident #11 was noted with purple discoloration under the left breast/ribs and left upper and forearm. It documented the ADON, administrator, and NP were notified. It documented orders were obtained for a stat x-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the discoloration and new order. There was no origin of the bruising identified in the nurse note. The note was signed by LPN #1.</p> <p>An Incident Report, dated 12/27/24, documented Resident #11 was noted with purple discoloration under their left breast/ribs and left upper and forearm. It documented the resident was unable to give a description. It documented the ADON, administrator, and NP were notified and new orders were received for stat X-ray: left rib series with posterior and anterior chest three view, left humerus two view, left forearm two view for a diagnosis of pain and discoloration. It documented the family was notified of the new order and discoloration. It documented injuries observed at time of incident: bruise left forearm, bruise left upper arm, bruise other describe (nothing was described in this section). The notes section documented discoloration to left upper and lower arm, left breast, and left side. It documented no injuries were observed post incident. It read in part, No statements found. There was no origin of the bruising identified in the incident report.</p> <p>On 01/29/25 at 2:44 p.m., the DON provided a sign in sheet for a full body transfer lift and sit to stand transfer inservice dated 12/27/24. There was no additional information related to this inservice provided to the survey team prior to exit. After filtering through a stack of papers on the desk, the administrator stated they had found the interviews and provided the following forms:</p> <p>a. a Resident Interview form for Resident #11. It read in part, Use as part of an Abuse investigation. There was no date on the form and the interviewer section was blank.;</p> <p>b. a Confidential Witness Statement, dated 12/27/24, signed by CNA #5 and the administrator read in part, I was about to give a bed bath, I notified a bruise to [their] left breast, ribs, upper arm forearm. I went to go get the nurse. I took care of her the day before and the bruise was not there. However [they] did complain it hurts during transfer with the sit-to-stand.;</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. a Confidential Witness Statement, dated 12/27/24, signed by LPN #1 and the administrator, read in part, I was notified by the CNA that there was a bruise to [left] arm and rib cage. I went to do an assessment. I called the NP, family and [unknown] order for X-ray. This bruise was not there the day prior.; and</p> <p>d. a Confidential Witness Statement, dated 12/27/24, signed by CNA #2 and the administrator, read in part, I observed that the sit to stand equipment hurts [Resident #11] arms when we tried to transfer. I notified the nurse. I was unaware of the bruise.</p> <p>The administrator was asked about the blanks on the resident interview form and they stated they had interviewed Resident #11 the day of the incident.</p> <p>On 01/29/25 at 2:58 p.m., LPN #2 stated they were made aware the administrator had the staff fill out the forms related to the bruising on Resident #11 today. LPN #2 stated they did not want staff getting in trouble for the administrator completing interviews after the fact when the investigation should have been done.</p> <p>On 01/30/25 at 8:21 a.m., LPN #1 was asked to explain the confidential witness statement dated 12/27/24 signed by them.</p> <p>On 01/30/25 at 8:23 a.m., LPN #1 stated the had went over what happened with the administrator yesterday. LPN #1 stated, I did not want to sign the form. They stated, It was yesterday. LPN #1 stated, I feel I should not have been put in that position. LPN #1 stated, I was told to sign it by The administrator. LPN #1 stated no one had asked them about any statements prior to yesterday. LPN #1 stated everything was in their nurse's notes. LPN #1 stated they made sure the x-ray order was in for the bruising. They stated they told the ADON and administrator and contacted the doctor. LPN #1 stated there was an inservice the following week regarding the lifts.</p> <p>On 01/30/25 at 8:28 a.m., CNA #2 stated the administrator had filled out the confidential witness statement and had me sign it. They stated it was completed yesterday. CNA #2 stated, It bothered me all day yesterday. They stated, I couldn't sleep. CNA #2 stated, [They] made it like we would be in some sort of trouble if we didn't sign it. CNA #2 stated it was filled out yesterday by the administrator who instructed CNA #2 to put the 12/27/24 date. CNA #2 stated they questioned the administrator about the date and the administrator informed them State would come and talk to them and instructed CNA #2 to tell them the date on the form. CNA #2 stated when the incident occurred, they told them about it.</p> <p>On 01/30/25 at 8:32 a.m., CNA #2 stated the day the incident occurred 12/27/24 with Resident #11, they went to help CNA #5. CNA #2 stated the resident was laying in bed and when they removed Resident #11's clothes we noticed bruising all over [them]. CNA #2 stated the nurse was notified at the time. CNA #2 sated they did not know where the bruising came from.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/30/25 at 8:47 a.m., CNA #5 stated the administrator had written out the entire witness statement. CNA #5 stated they did not know anything about the statement until the administrator called them into the office yesterday. CNA #5 stated they had reported the bruising to the nurse the day it occurred. They stated yesterday the administrator told them I'm going to write this statement, I'm going to need you to sign it. CNA #5 stated the administrator stated if anyone asked, they were to say it was already documented. CNA #5 stated they did not feel good about it because it was forging something and they did not want to get in trouble. CNA #5 stated the administrator instructed, You sign it but, I'm going to write it. CNA #5 stated, I didn't want to sign it because it wasn't in my handwriting and this wasn't my report. CNA #5 stated it was weeks ago and they should have already had it together.</p> <p>On 01/30/25 at 8:50 a.m., CNA #5 stated on 12/27/24 they walked into Resident #11's room to give them a bed bath with CNA #2. CNA #5 stated the resident was still in bed. CNA #5 stated as they removed the resident's clothes, they observed a bruise to their back and breast area. CNA #5 stated they were to get the nurse who examined the resident. CNA #5 stated they did not know where the bruising came from. They stated they received an inservice on lifts on a Tuesday because they always received inservices on paydays (12/27/24 was a Friday). They stated they could not remember the exact date of the inservice.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>49701</p> <p>Based on observation and interview, the facility failed to ensure a call cord was within reach for one (#23) of 13 sampled residents whose call cord availability was observed.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Call Lights policy, read in part, Always be sure the resident has a functioning call light that is the easiest type for them to use. Always place the call light in an accessible location to where the resident is located in their room.</p> <p>Resident #23 had diagnoses which included cerebral infarction and hemiplegia of dominant side.</p> <p>Resident #23's quarterly assessment, dated 11/07/24, documented the resident had functional range of motion limitations to all four extremities and was dependent on staff for all activities of daily living.</p> <p>On 01/27/25 at 12:51 p.m., a touch pad call light was observed attached to the curtain against the wall while Resident #23 was in a specialized mobile chair in front of their bed. The touch pad was not within their reach.</p> <p>On 01/27/25 at 12:53 p.m., LPN #1 stated Resident #23's touch pad call light was not where it should have been and then clipped the touch pad to Resident #23's blanket in their lap. LPN #1 stated Resident #23 would be unable to call for assistance without the touch pad call light in reach.</p> <p>On 01/30/25 at 9:01 a.m., the ADON stated call lights were to always be in reach of the residents.</p>		