STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375551	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Park West Rehabilitation & Skilled Care	3110 Healthplex Drive Norman, OK 73072

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure residents who received dialysis had pre and post monitoring for 1 (#3) of 3 sampled residents reviewed for dialysis.The DON reported 94 residents resided in the facility.Findings:The Dialysis-Hemodialysis policy, dated 02/12/20, read in part, Pre-Dialysis: Section A to be completed by the sending community licensed nurse and to accompany the patient to dialysis center.Post Dialysis: Community nurse to complete Section B with dialysis center information. Community nurse to access and complete Section C.Resident #3's undated facesheet showed a diagnosis of dependence on dialysis.A physician order, dated 04/14/25, showed dialysis on Monday, Wednesday, and Friday's.The resident's medical record was reviewed from 04/16/25 through 05/12/25 and showed 1 pre-dialysis communication report dated 05/02/25.On 07/21/25 at 12:56 p.m., the DON reported there should have been a pre and post dialysis form for everyday they went to dialysis.

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/22/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were free from significant medication errors.On 07/22/25 at 2:11 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation.On 07/22/25 at 2:29 p.m., the administrator, DON, and the corporate nurse consultant were notified of the IJ situation. An IJ template was provided to the administrator.On 07/23/25 at 1:03 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal read in part, Regional Nurse Consultant will educate the Director of Nursing on identification of significant medication errors and administration of medication per physician orders. DON/Designee will educate all licensed nurses and certified medication aides by 2359 [11:59 p.m.] on 7/23/2025 regarding administering medication according to physician orders and identification of significant medication errors. Medication aides and Licensed nurses will document medication administration in the eMAR. Any licensed nurse or certified medication aide not educated by 2359 [11:59 p.m.] on 7/23/2025 will not be allowed to work until they have received education.An audit of current residents missing significant medications for the last 7 days was conducted and completed by 2359 [11:59 p.m.] on 7/23/2025 by nursing management to assure that significant medications are given as ordered by physician.Any significant medication errors found during the audit will be reviewed by the DON. The medical director will be notified of the findings for any further recommendations.The IJ was lifted, effective 07/23/25 at 11:59 p.m., when all components of the plan of removal had been completed. Staff interviews regarding significant medication errors and administering medications as ordered by the physician was completed and all components of the plan of removal was reviewed.Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for 1 (#3) of 7 sampled residents reviewed for significant medication errors.The DON reported 94 residents resided in the facility.Findings:An undated medical diagnosis sheet showed Resident #3 admitted to the facility on [DATE] with diagnoses which included seizures, chronic kidney disease, dependence on dialysis, hypothyroidism, cardiomegaly, and atherosclerotic heart disease.A physician order, dated 04/16/25, showed Levetiracetam (an anticonvulsant) 500 mg tablet, one tablet every 12 hours for seizures.A medication administration record, dated 04/16/25 to 05/12/25, showed 9 out of 26 missing morning doses of Levetiracetam (an anticonvulsant) 500mg on 04/18/25, 04/23/25, 04/25/25, 04/28/25, 04/30/25. An emergency department physician note, dated 04/30/25 at 10:50 p.m., showed Resident #3 was presented for seizures and was given Keppra due to the missed doses. The physician noted Resident #3 could discharge and reiterated the importance of twice daily dosing of her Levetiracetam.An interdisciplinary progress note, dated 05/01/25 at 8:02 a.m., showed the Resident returned from the hospital around 3:00 a.m. via EMS. Family reported resident had received IV Levetiracetam for seizure activity. Writer reported to family that her meds will be given prior to Dialysis from now on.On 07/23/25 at 1:05 p.m., the DON stated they were not aware of why the resident went to the emergency room or the significant medication error.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician was notified timely of a urinalysis for 1 (#2) of 3 sampled residents reviewed for lab results.The DON reported 94 residents resided in the facility. Findings:A facility policy titled Laboratory and Radiology Service Coordination, dated 01/26/23, read in part, Notify physician of results; Reference change of condition policy and procedures for immediate and non-immediate notification guidelines; and document physician notification.An undated facesheet showed Resident #2 admitted to the facility with diagnoses of atrial fibrillation, heart failure, and hypertension.A nurse note, dated 03/22/25 at 7:53 p.m., read in part, Patient complained of bladder pain and pressure. New order received for UA. UA was obtained and wnl. Patient and family requested to be sent to ER. Patient and family reinformed the UA results were normal. Patient was still adamant about going to the ER. New orders received to sent [sic] to ER for evaluation.The residents medical record did not show the UA results, or the physician was notified of the results.A hospital Discharge summary, dated [DATE], read in part, Reason for admission: Pseudomonas urinary tract infection. She was having bladder spasms.On 07/21/25 at 1:05 p.m., the DON reported the facility policy was not followed and did not document the physician was notified of the UA results.