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	01/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were:a. transcribed following admission orders, andb. blood pressure medications were administered following physician orders to prevent significant medication errors for 2 (#1 and #2) of 3 sampled residents reviewed for medication administration.The administrator identified 95 residents resided in the facility. Findings:1.An undated facility process Drug regimen review and transcribing admission orders showed steps for putting admission orders from the hospital were to print off the discharge orders from the hospital, enter each order, and when all orders are put in, sign and date. The process showed the ADON would take the noted orders to morning meetings, so a drug regimen review could be completed, and the noted orders would then be given to the DON.A hospital discharge medication list, dated 12/23/25, showed Resident #1's medication orders on admission were:a. Eliquis (blood thinner) 5 mg one tablet twice a day,b. Famotidine (acid reflux) 20 mg one tablet at bedtime,c. Culturelle (probiotic supplement) one twice daily, andd. Linezolid (antibiotic) 600 mg one every 12 hours till 12/29/25.Physician's orders, dated 12/23/25, showed medications ordered for Resident #1 were the following:a. Duloxetine HCL (antidepressant) 60 mg one tablet one time a day for depression.b. Amlodipine Besylate (blood pressure) 5 mg one tablet one time a day for hypertension. Hold for systolic BP <110, diastolic BP <60, or pulse <60,c. Atorvastatin calcium (cholesterol/triglyceride reducer) 20 mg one tablet one time a day for hyperlipidemia,d. Levothyroxine (thyroid) 100 mcg one tablet one time a day for hypothyroidisme. Valsartan (blood pressure) 80 mg one tablet one time a day for hypertension, andf. Celecoxib (non-steroidal anti-inflammatory) 200 mg one capsule daily as needed for pain.An admission note, dated 12/23/25, showed Resident #1 arrived at the facility via medical transport from the hospital. The admission note showed the resident was previously seen at the hospital for hematuria and cellulitis and was taking an antibiotic.A medication record, dated 12/23/25 through 01/12/26, showed Resident #1 received the incorrect medication:a. Duloxetine HCL 60 mg 12/24/25 through 01/06/26,b. Amlodipine Besylate 5 mg 12/24/25, 12/25/25, 12/27/25, 12/28/25, 12/30/25, 01/01/26, and 01/03/26 through 01/06/26,c. Atorvastatin calcium 20 mg 12/24/25 through 01/06/26,d. Levothyroxine 100 mcg 12/24/25 through 01/06/26, ande. Valsartan 80 mg 12/24/25, 12/25/25, 12/27/25, 12/28/25, 12/30/25, 01/01/26, and 01/03/26 through 01/06/26.The medication record, dated 12/23/25 through 01/12/26, showed Resident #1 did not receive the ordered medications from the admission orders from the hospital:a. Eliquis 5 mg one tablet twice a day, b. Famotidine 20 mg one tablet at bedtime, c. Culturelle one twice daily 12/24/25 through 01/06/26, andd. Linezolid 600 mg one every 12 hours 12/24/25 through 12/29/25.An admission assessment, dated 12/27/25, showed Resident #1 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation and wound infection. The assessment showed Resident #1's cognition was moderately impaired with a BIMS score of 11.The medication administration record, dated 01/05/26, showed Resident #1's blood pressure was 105/69 and the blood pressure medication was not held per physician ordered parameters.A care plan (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	note, dated 01/06/26, showed the family expressed concerns regarding the resident's abnormal blood pressure readings and current blood pressure medication orders. The note showed the concerns would be followed up by the doctor.An incident report, dated 01/06/26, showed the pharmacy contacted the DON with a concern for potential alteration in Resident #1's medication. The report showed the resident's medication was reviewed with the physician and new medication orders were received and updated.A Root Cause Analysis Five Ways worksheet, dated 01/07/26, showed:a. Resident #1 was admitted on [DATE], the same day as Resident #2. Resident #2's medications were put on the orders for Resident #1,b. the medication orders for Resident #1 and Resident #2 were put in by the same nurse,c. the drug regimen review was completed by the same nurse that put in the medication orders,d. the ADON did not recheck the drug regimen review,e. The clinical team did not double-check the orders, andf. the vital sign parameters for blood pressure medication were not followed by staff, and abnormalities were not reported to the physician.2. A hospital discharge medication list, dated 12/23/25, showed Resident #2's medication order on admission were:a. Duloxetine HCL 60 mg one tablet one time a day for depression,b. Amlodipine Besylate 5 mg one tablet one time a day for hypertension. Hold for systolic BP <110, diastolic BP <60, or pulse <60,c. Atorvastatin calcium 20 mg one tablet one time a day for hyperlipidemia,d. Levothyroxine 100 mcg one tablet one time a day for hypothyroidism,e. Valsartan 80 mg one tablet one time a day for hypertension,f. Celecoxib 200 mg one capsule daily as needed for pain, andg. Prednisone (steroid) 40 mg one tablet daily.Physician orders, dated 12/23/25, showed medications ordered for Resident #2 included:a. Eliquis 5 mg one tablet twice a day,b. Famotidine 20 mg one tablet at bedtime, andc. Culturelle one twice daily,The medication record, dated 12/23/25 through 01/12/26, showed Resident #2 did not receive the ordered medications from the admission orders:a. Duloxetine HCL 60 mg one tablet one time a day 12/24/25 through 01/06/26,b. Amlodipine Besylate 5 mg one tablet one time a day 12/24/25 through 01/06/26,c. Atorvastatin calcium 20 mg one tablet one time a day 12/24/25 through 01/06/26,d. Levothyroxine 100 mcg one tablet one time a day 12/24/25 through 01/06/26,e. Valsartan 80 mg one tablet one time a day 12/24/25 through 01/06/26,f. Celecoxib 200 mg one capsule daily 12/24/25 through 01/06/26, andg. Prednisone 40 mg one time daily 12/24/25 through 12/29/25.The medication record, dated 12/23/25 through 01/12/26, showed Resident #2 received the incorrect medication:a. Eliquis 5 mg one tablet twice a day 12/24/25 through 01/06/26,b. Famotidine 20 mg one tablet at bedtime 12/24/25 through 01/06/26, andc. Culturelle one twice daily, 12/24/25 through 01/06/26.An admission assessment, dated 12/28/25, showed Resident #2 was admitted on [DATE] with diagnoses which included hypertension and osteoporosis. The assessment showed Resident #2's cognition was intact with a BIMS score of 13.A Root Cause Analysis Five Ways worksheet, dated 01/07/26, showed:a. Resident #2 was admitted on [DATE], the same day as Resident #1. Resident #2's medications were put on the orders for Resident #1,b. the medication orders for Resident #1 and Resident #2 were put in by the same nurse,c. The drug regimen review was completed by the same nurse that put in the medication orders,d. the ADON did not recheck the drug regimen review,e. the clinical team did not double-check the orders, andf. the vital sign parameters for blood pressure medication were not followed by staff, and abnormalities were not reported to the physician.On 01/13/26 at 9:30 a.m., RN #1 stated Resident #1 and Resident #2 were admitted on the same day, the same nurse put in both medication orders, and the nurse switched the orders when entering. RN #1 stated another nurse should have double checked the orders to make sure the orders were entered correctly but that did not happen. RN #1 stated the pharmacy was checking the medications and found there to be possible errors. RN #1 stated this was a serious event, but did not change the residents' condition, and the nurse was suspended. RN #1 stated in-services had been conducted.On 01/13/26 at 12:30 p.m., the DON stated blood (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure medication withhold parameters ordered should be held when the readings were below those parameters.On 01/13/26 at 3:05 p.m., the ADON reported they failed to double check Resident #1 and Resident #2's medications for accuracy. The ADON reported the medication errors were really bad, but no reactions happened to either resident.