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	01/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35474 Based on record review and interview, the facility failed to ensure proper beneficiary notification was provided for two (#54 and #66) of three sampled residents reviewed for beneficiary notifications. The Beneficiary Notice-Residents discharged Within the Last Six Months form showed seven residents had remained in the facility after they had been discharged from skilled services with skilled days remaining. Findings: 1. The Beneficiary Notice-Residents discharged Within the Last Six Months form showed Resident #54 was discharged from skilled services, had skilled days remaining, and stayed in the facility as a long term care resident after the discharge from skilled services. The SNF Beneficiary Protection Notification Review form showed Resident #54 was discharged from skilled services on 09/29/24 and the resident and/or resident representative had not been provided an ABN. 2. The Beneficiary Notice-Residents discharged Within the Last Six Months form showed Resident #66 was discharged from skilled services, had skilled days remaining, and stayed in the facility as a long term care resident after the discharge from skilled services. The SNF Beneficiary Protection Notification Review form showed Resident #66 was discharged from skilled services on 08/28/24 and the resident and/or resident representative had not been provided an ABN. On 01/28/25 at 5:59 p.m., the social services director stated Resident #54 and Resident #66 had not been provided ABNs. On 01/30/25 at 2:42 p.m., the social services director stated they thought the MDS coordinator had provided the ABNs, but they had not provided one for Resident #54 or Resident #66. On 01/30/25 at 2:46 p.m., the administrator stated they had asked the social services director about ABNs and they stated they had not been trained on beneficiary notifications.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 35474 Based on record review and interview, the facility failed to ensure quarterly assessments were completed not less than once every three months for one (#31) of 22 sampled residents whose assessments were reviewed. The administrator identified 90 residents who resided in the facility. Findings: Resident #31 had diagnoses which included hypertension. The electronic health record showed a quarterly assessment had been completed on 03/27/24 and 06/27/24, and an annual assessment had been completed on 09/25/24. No other assessments had been documented after the 09/25/24 annual assessment. On 01/30/25 at 12:21 p.m., MDS coordinator #1 reviewed the electronic health record for Resident #31 and stated the last assessment completed was the annual assessment on 09/25/24. They stated they did not know why a quarterly assessment had not been completed in December 2024. On 01/30/25 at 12:24 p.m., the DON stated a quarterly assessment should have been completed in December for Resident #31.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure assessments were encoded and transmitted for two (#70 and #184) of 22 sampled residents whose assessments were reviewed. The administrator identified 90 residents who resided in the facility. Findings: 1. Resident #70 had diagnoses which included hypertension. The electronic health record showed the last assessment completed was a discharge from part A services assessment, dated 10/14/24. The Discharge Instructions for Care form showed Resident #70 was discharged from the facility on 10/31/24. On 01/30/25 at 12:26 p.m., MDS coordinator #1 reviewed the electronic clinical record for Resident #70 and stated they did not know why a discharge return not anticipated assessment had not been completed on 10/31/24 when the resident discharged home. 2. Resident #184 had diagnoses which included paraplegia. The electronic clinical record showed Resident #184 was an active resident. The electronic clinical record showed discharge return anticipated assessments, dated 12/07/24 and 12/24/24, with no re-entry assessments completed. On 01/30/25 at 3:34 p.m., the DON and MDS coordinator #1 reviewed the electronic clinical record for Resident #184. The DON stated the resident had returned to the facility on [DATE] and 12/25/24. MDS Coordinator #1 stated they should have completed re-entry assessments on 12/08/24 and 12/25/24. The DON stated the previous MDS coordinator had not been completing assessments as required.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 41220 Based on record review and interview, the facility failed to complete a baseline care plan for four (#26, #34, #45, and #60) of seven sampled residents reviewed for baseline care plans. The administrator identified 90 residents in the facility. Findings: 1. Resident #26 had diagnoses which included congestive heart failure. 2. Resident #34 had diagnoses which included non Alzheimer dementia. 3. Resident #45 had diagnoses which included hemiplegia. 4. Resident #60 had diagnoses which included diabetes mellitus with chronic kidney disease Record reviews did not document baseline care plans were completed for these residents. On 01/28/25 at 5:35 p.m., the DON stated they had looked through the records and was unable to locate a baseline care plan for these residents.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 35474 Based on record review and interview, the facility failed to ensure a discharge summary which included a recapitulation of the resident's stay was completed for one (#70) of two sampled residents who were reviewed for discharge. The administrator identified 90 residents who resided in the facility. Findings: Resident #70 had diagnoses which included hypertension. The Discharge Instructions for Care form showed the resident was discharged from the facility to home on 10/31/24. The undated Interdisciplinary Discharge Summary form in the electronic clinical record was blank in all sections except dietary and activities. The discharge summary did not contain a recapitulation of the resident's stay. On 01/30/25 at 12:30 p.m., the DON stated each department was to complete their section of the Interdisciplinary Discharge Summary form in the electronic clinical record. The DON stated they monitored the discharge summaries and knew they had not been completing them to include a recapitulation of the residents stay.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview, the facility failed to ensure weights were obtained and meal percentages were monitored as ordered by the physician for four (#11 and #56, #60, and #63) of four sampled residents reviewed for nutrition The administrator identified 90 residents in the facility. Findings: The Nutritional Services policy, dated 01/12/18, read in parts, Changes are reviewed during morning meeting .Diets .Weights: loss/gain .Appetite: decrease in oral intake of less than 25%. 1. Resident #11 had diagnoses which included cerebral infarction and underweight. A Physician Order, dated 04/20/24, showed a house shake was to be given at breakfast and lunch for the diagnosis of underweight. The care plan, dated 11/11/24, included a plan for altered nutritional status. A Physician Order, dated 12/31/24 showed the resident was to be weighed weekly. The Resident Weight Record for Resident #11 showed weights were obtained monthly, not weekly as ordered, with a weight loss in one month of 4.4 pounds. The ADL worksheet for December 2024 showed 25 meal percentages recorded out of 93 opportunities. The January 2025 ADL record showed 50 meal percentages out of 86 opportunities. 2. Resident #56 had diagnoses which included fracture of the femur. The Care Plan, dated 12/06/24, showed to monitor oral intake of food and fluid. A Physician Order, dated 12/07/24, showed the resident was to be weighed weekly. The ADL worksheet for January 2025 showed 50 meal percentages out of 86 opportunities. 3. Resident #60 had diagnoses which included diabetes mellitus with diabetic chronic kidney disease. A Physician Order, dated 12/11/24 showed the resident was to be weighed weekly. The December 2024 ADL sheet for meal percentages showed four meal percentages out of 93 opportunities. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2025 ADL sheet for meal percentages showed 33 meal percentages out of 86 opportunities. A printed list of weights for Resident #60 was provided by the DON. It showed one weight was obtained in December and one weight in January. 4. Resident #63 had diagnoses which included cerebral infarction. The December 2024 MAR showed the resident was to be weighed weekly for 4 weeks. The Resident Weight Record showed the first weight 12 days after admission in December 2024 and a second weight in January. The two weights documented a weight loss of 15.8 pounds. The ADL record for December 2024 documented 34 meal percentages out of 57 opportunities. On 1/28/25 at 3:27 p.m., CNA # 1 stated they were to document meal intake on paper ADL worksheets and inform the nurse if intake less than 50 percent. On 1/28/25 at 2:48 p.m., the ADON stated weight loss was monitored and if it was a five pound loss or more they implemented interventions, including a dietary consult and physician contact. They stated resident meal intake percentage was documented in the ADL. On 1/30/25 at 9:39 a.m., the ADON stated they were responsible for monitoring weights. On 1/30/25 at 10:20 a.m., the ADON stated the facility policy was to weigh all residents on the day of admission or the next day. On 1/30/25 at 3:05 p.m., the DON stated the inconsistent documentation of meal percentages was due to a lack of supervision. 41220 51849

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35474 Based on record review and interview, the facility failed to ensure residents who received dialysis were assessed after dialysis for one (#60) of one sampled resident who was reviewed for dialysis. The DON identified three residents who required dialysis. 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 patient to the dialysis center.Post Dialysis: Community nurse to complete Section B with dialysis center information. Community nurse to assess and complete Section C. Resident #60 had diagnoses which included end stage renal disease. The Dialysis Pre/Post Communication Report forms, read in part, This section to be completed by Nursing Home Staff upon resident return and placed in clinical record .Access Type/Assessment. A physician's order, dated 05/28/24, showed the resident was to receive dialysis weekly on Monday, Wednesday, and Friday. The quarterly assessment, dated 10/27/24, showed the resident was cognitively intact for daily decision making and received dialysis while a resident in the facility. The treatment record, dated December 2024, read in part, Dialysis Monday, Wednesday and Friday on 1 time per day Monitor shunt/graft/fistula for S/X of infection and adequate circulation. The time on the treatment record for the monitoring was documented for 9:00 a.m. The treatment record and the Dialysis Pre/Post Communication Report forms, dated 12/09/25 and 12/16/24, did not show the resident's fistula had been assessed after dialysis. The treatment record, dated January 2025, read in part, Dialysis Monday, Wednesday and Friday on 1 time per day Monitor shunt/graft/fistula for S/X of infection and adequate circulation. The time on the treatment record for the monitoring was documented for 9:00 a.m. The treatment record and the Dialysis Pre/Post Communication Report forms, dated 01/22/25, 01/24/25, and 01/27/25, did not show the resident's fistula had been assessed after dialysis. On 01/28/25 at 11:54 a.m., Resident #60 stated facility nurses assessed their dialysis access site from time to time, but not every time they returned from dialysis. On 01/28/25 at 4:10 p.m., LPN #2 stated residents were assessed after dialysis and they documented on the dialysis communication forms. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 4:56 p.m., the DON stated the charge nurses were to assess residents before and after dialysis and document on the dialysis communication forms. The DON stated they added vital signs twice daily and monitoring the dialysis access site on the days the residents were scheduled dialysis because the nurses did not always complete the dialysis communication forms. The stated the administrative staff monitored documentation weekly to ensure residents were assessed before and after dialysis, but they had some staffing changes and the post dialysis assessments had not been consistently completed

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35474 Based on record review and interview, the facility failed to ensure medications were reviewed monthly by the consultant pharmacist and the pharmacy recommendations were addressed by the physician for one (#60) of five sampled residents who were reviewed for unnecessary medications. The DON identified 89 residents who received medications in the facility. Findings: The Medication Regimen Review and Reporting policy, dated January 2024, read in part, The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly .The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. Resident #60 had diagnoses which included chronic pain. The Consultant Pharmacist Recommendation to Physician, dated 05/31/24, read in part, In hemodialysis patients, gabapentin is titrated to effect up to 300 mg 3 times per week given after hemodialysis on dialysis days. Some experts recommend cautious titration to a max of 300 mg/day in select patients requiring additional pain control. It may be reasonable to consider reducing the dose for this medication. The consultant pharmacist report was addressed by the physician and dated 01/29/25. Review of the clinical record and the monthly medication regimen reviews provided by the DON did not show a medication regimen review by the consultant pharmacist had been completed for December 2024. On 01/29/25 at 11:03 a.m., the DON stated they could not locate the medication regimen review for December 2024. They stated they asked the nurse practitioner to review and address the pharmacist recommendation dated 05/31/24 on 01/29/25. They stated they did not know why the 05/31/24 recommendation had not been previously addressed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30267 Based on observation and interview, the facility failed to label and store medications according to acceptable standards of practice for two medications observed during a review of medication/treatment carts and medication storage rooms. The ADON identified nine carts and two medication storage rooms. Findings: On [DATE] at 8:30 a.m., LPN #1 removed a bag labeled for Resident #60. Inside the bag was a multi-use insulin pen which was labeled for Resident #28. LPN #1 removed the bag labeled for Resident #28 which contained an unlabelled multi-use insulin pen with insulin degludec. LPN #1 stated the insulins were probably switched by mistake. After checking the medication room, LPN #1 stated they would have to order insulin for Resident #60 from the pharmacy. On [DATE] at 8:40 a.m., the 600 hall medication storage room was observed with LPN #1. Inside the medication storage room was a refrigerator with a padlock latch present on the main refrigerator door, but no padlock to secure the door. LPN #1 opened the refrigerator and an unlocked metal lock box was observed secured to a shelf in the refrigerator. LPN #1 opened the lock box and found 30 syringes of liquid Ativan (a benzodiazepine). LPN #1 stated the Ativan was labeled for an expired resident. The LPN stated the resident expired a few weeks ago. On [DATE] at 9:20 a.m., the ADON stated they went around to each nurse and medication aide once a week and asked if there were any controlled drugs to destroy. The ADON stated they were not aware the Ativan was in the facility. The ADON stated there was no narcotic count sheet associated with the liquid Ativan. The ADON stated it was the responsibility of the floor nurse receiving the medication to make out the narcotic count sheet if one is not present. The ADON stated medications received from the facility's primary pharmacy had narcotic count sheets attached, but the liquid Ativan was received from a hospice pharmacy. The ADON stated without a narcotic count sheet, none of the nurses were aware of the medication, and the medication was not routinely reconciled for misappropriation. The ADON stated they were aware insulin was ordered for Resident #60. The ADON stated all stored medications required proper labeling.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for one (#60) of five sampled residents whose labs were reviewed. The DON identified 45 residents who had routine labs ordered. Findings: Resident #60 had diagnoses which included diabetes mellitus. Physician orders, dated 05/28/24, showed the facility was to complete a CBC every 6 months in March and September; and the facility was to complete a hemoglobin A1C every 3 months in March, June, September, and December. Review of the clinical record did not show a CBC had been completed in September 2024 or that a hemoglobin A1C had been completed in June, September, or December 2024. On 01/28/25 at 5:04 p.m., the DON stated the ADON was responsible to ensure labs were completed as ordered by the physician. They stated labs had not been completed because they were not put into the lab company's ordering system.