	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION		SURVEY
		376034	B. WING				C /17/2013
NAME OF PE	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				6202	EAST 61ST STREET		
MAPLEWO	DOD CARE CENTER			TUL	SA, OK 74136		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XØ) Completion Date
F 000	INITIAL COMMENTS	1	F	000			
	12/16/13 through 12/ #OK00D43512, #OK0 #OK00043443, #OK0	13 through 12/13/13 and					
	The following abbrev this text: ADON - Assistant Di CMA - certified medic CNA - certified nurse DON - director of nur LPN - licensed pract RN - registered nurse DA - dietary alde DM - dietary manage SS - social services	cation aide aide rsing ical nurse e					
	adl - activities of dall A-fib - atrial fibrillatio BID - twice daily bil - bilateral BLE - bilateral lower c - with CHF - congestive he	extremities			:	1899 I.S.	2.
	c/o - complaint of cont - continue COPD - chronic obsi dc - discontinue DVT - deep vein thro dx - diagnosis fx - fracture L - laft med , medication	tructive pulmonary disease ombosis				"x ×	

Any deficiency statement ending with an asteriek (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other satesments 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 oited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-88) Previous Versions Obsolete

10.00

Facility ID; NH7226

If continuation sheet Page 1 of 181

		MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A. BUILDING	E CONSTRUCTION	(X3) DATE SI COMPLE	
					c	
		376034	B. WING		12/17	7/2013
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER			6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETION DATE
F 000	Continued From page mg - milligram N/O - New order NS - normal saline po - by mouth ppm - parts per millio pm - as needed q - every qd - every day r or rt - right sq - subcutaneous s/sx - signs and symp TAR - treatment adm T/O - telephone orde tx - treatment vac - vaccum w/c - wheelchair wk - week w/o - without	n otoms inistration record	F 00	0		
F 157 SS≍H	A facility must immed consult with the resid known, notify the resid accident involving the injury and has the po- intervention; a signifi physical, mental, or p deterloration in healt status in either life the clinical complications significantly (i.e., a n existing form of treat consequences, or to	ROOM, ETC) liately inform the resident; lent's physician; and if ident's legal representative ly member when there is an e resident which results in tential for requiring physician cant change in the resident's osychosocial status (i.e., a h, mentai, or psychosocial reatening conditions or s); a need to alter treatment eed to discontinue an ment due to adverse commence a new form of sion to transfer or discharge	F 15	 Without admitting or denying validity or existence of the alled deficiencies, Maplewood Care provides the following plan of correction. F157 1. On 12/14/13, resident #3' physician was notified of har the physician ordered her t on dilaudid 1mg per peg q routinely at this time. 2. All residents receiving ro and/or as needed pain med have the potential to be affect pain screen was completed or to the physician of the physician was completed or to the pain screen was completed or to the physician was completed or to the physician between the potential to be affect pain screen was completed or to the physician between th	ged Center s er pain. o begin 4 hours utine ications cted. A	1/21/14

Evant ID: NU5U11

Facilly ID: NH7226

If continuation sheet Page 2 of 181

STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	I. 0938-039 SURVEY LETED
		375034	B. WING			C 17/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1//2010
				6202 EAST 61ST 8TREET		
MAPLEW	DOD CARE CENTER			TULSA, OK 74136		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X6)
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLÉTIO DATE
F 157	Continued From pag	- 2		7 3. Nursing staff were in	serviced by	
1.07		82	FID	the Risk Manager o	n 12/17/13	
	§483.12(a).		1	the Risk Manager o		
	The feellity must also	a promotily notify the real-last		regarding notification o	r physicians	
		o promptly notify the resident sident's legal representative		with increased or uncont	rolled pain.	1
		nember when there is a		4. Audits will be compl	eted to	[
		commate assignment as		ensure residents are	effectively	l
		(e)(2); or a change in		treated for pain weekly	x 4 monthly	1
		Federal or State law or	}	x 3 and quarterly x 1	and finding	
	regulations as specif	fied in paragraph (b)(1) of		x 3 and quarterly x 1	and mining	
	this section.		1	reported in the Quality	y Assurance	
				Meeting.		
		ord and periodically update		_		
		one number of the resident's	1			
	legal representative	or Interested family member.				
	This REQUIREMEN	T is not met as evidenced				
	by:					
	Based on observati	on, Interview, and record				
	review, it was deterr	nined the facility failed to				
		of increased pain for one (#3)				
	of thirteen sampled	residents who were reviewed				1
		ed in actual harm for resident				
		tified 72 residents as				
		d/or as needed pain				
	medications. Findin	gs:				
		on pain, dated 04/2013,				
	documented, "Ass					1
		es a review of known				1
		ions that commonly cause or				
		s to painReview for any				1
		resident currently is receiving Ints should occur on		1		{
		cility, at each quarterly review,		1		1
		significant change in		1		
		fime pain is suspectedThe				1
		he individual's pain and				
	consequences of pa		1	1		

.

		MEDICAID SERVICES				OMB NC	_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	LETED
			1				0
		375034	B, WING			12/	17/201
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER				12 East 6187 Street ILSA, ok 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefd Tag	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	COMPI DA
F 157	Continued From page	3 3	F1	57			
	Popidont #2 was ada	nitted to the facility on	1]
		ses that included multiple					
		ic pain, dysarthria, joint					
	and myalgia. The re-	e pressure ulcers, diabetes, sident received all	Į				
	medications via a per tube.	rcutaneous gastrostomy					}
		ated 02/2013, documented aceive Norco 7.5/325 mg,	l	1			
	two tablets every eig	ht hours for pain, Baclofen					1
		s for muscle spasms, six hours for spasms, and	1	1			
		ng every fours hours as					
		dated 02/08/13 at 7:00 p.m., ease the resident's Norco to obt hours for pain.					
		dated 02/17/13, documented					
	the resident could re every eight hours as	ceive Norco 7.5/325 mg needed for pain.					
		d 02/19/13, documented, "					
1	[Name withheld] [con	npialns of[pain[one] tab		Ì			
	it back to 2 tab [sic].						
l.		dated 02/19/13, documented					
		medication back to Norco sts every eight hours routinely					
		lasted 05/2013, documented					
		eceive Norco 7.5/325 mg, ht hours, acetaminophen 640					
		s, and naproxen 250 mg					1

.

	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULT	OPLE	CONSTRUCTION	OMB NO	APPROVE 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI			COMP	ETED
		375034	B. WING			1 1	17/2013
NAME OF PI	ROVIDER OR SUPPLIER			ទា	TREET ADDRESS, CITY, STATE, ZIP CODE		
				62	202 EAST 61ST STREET		
MAPLEWO	DOD CARE CENTER			Т	UL\$A, OK 74136		
(X4) 1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	D	1	PROVIDER'S PLAN OF CORRECTION		(%5)
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
TAG	REGULAIORIOR	LOC IDENTIF TING INFORMATION	TAG		DEFICIENCY	UALE .	
		······································	1				
F 167	Continued From page	e 4	F	157			
	every twelve hours a	s needed for pain					
	Resident #3 was here	pitalized on 05/20/13 and					
	re-admitted to the fac		[
		n/start-up orders, dated		- 1			
	a de la superior recenter a participation de la superior	ed the resident was to receive					
		o tablets every eight hours nphen 650 mg every four	{				
	hours as needed for		1				
	The diagnosis depart	iption included Sacral ulcer	1				
		lerosis, dysarthria, left leg	1	3			
		tracture of the hand.					
		ssion/start-up order, dated					
		ed the resident was to receive	1				
		ry four hours as needed for					
	needed for pain.	250 mg every 12 hours as					
	A physician order, da	ated 06/14/13, documented to					
	increase the residen	t's Norco 7.5/325 to two	(1		(
	tablets every six hou	ITS.	ł				
	A quarterly assessm	ent, dated 06/18/13,					ł
		ident was cognitively intact,	1				1
		ance from staff for bed			1)
	mobility, transfers, a	and any and an exception of a company			}		1
		ident's upper and lower	1		1		}
		notion was impaired due to			1		1
	joint contractures.		1)		
		the resident was on a			1		
		lication regimen and had			1		ł
		pain medication. It was also	1				1
		ident's pain was frequent with on a pain scale of one to ten.	1				1
	en mensity of eight,	on a pain scale of one to ten.	(1		(

- ----

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					0,0938-039
	IDENTIFICATION NUMBER:				PLETED
		1			С
	375034	B. WING		12	/17/2013
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
DOD CARE CENTER			6202 EAST 61ST STREET TULSA, OK 74136		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	id Prefix Tag	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	IN SHOULD BE	(X5) COMPLETION DATE
Continued From page	a 5	Ed	57		
e enterne e i terni peg		1	57		
· · · · · · · · · · · · · · · · · · ·		j	1		1
pressure ulcer. Ther	e were three unstaged	}			}
slough/eschar pressu	ure ulcers.	1			
A physician order, da	ated 06/18/13, documented to	1			
increae the resident's	s Norco7.5/325 mg to two				
tablets every four hor	urs.				
An assessment of co	ontracture risk was	1			
A set of the second					
					1
	, and a the second s				1
					1
extremity flexion con	tractures. It was also	{			
documented the residence of the contracted.	dent's hands were				
					1
The facility admissio	n/start-up orders, dated				1
08/09/13, document	ed the resident was to				
					1
A routine pain medic readmission.	ation was not ordered on				
seven days in both l	egs and feet. The				
assessment reveale	d that pain was increased				1
	PEDEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DOD CARE CENTER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page It was also document stage III pressure uico pressure uicor. There slough/aschar pressure tablets every four hore An assessment of co completed on 06/20/ This indicated the real required a regular po- bed and chair. Predi documented as bilate extremity flexion con documented as bilate extremity flexion con documented the real contracted. The resident was ho non-healing pressure the facility on 08/09/ The facility admissio 08/09/13, document receive acetaminopit as needed for pain a tablets every four hor A routine pain medic readmission. A facility pain assess 08/09/13. The asses resident had experies seven days in both fa	AF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 5 It was also documented the resident had three stage III pressure ulcers and one stage four pressure ulcer. There were three unstaged slough/eschar pressure ulcers. A physician order, dated 06/18/13, documented to increae the resident's Norco7.5/325 mg to two tablets every four hours. An assessment of contracture risk was completed on 06/20/13. The total score was ten. This indicated the resident was at risk and required a regular positioning schedule for both bed and chair. Predisposing factors were documented as bliateral upper and lower extremity flexion contractures. It was also documented the resident's hands were contracted. The resident was hospitalized on 07/25/13 for non-healing pressure ulcers and re-admitted to the facility admission/start-up orders, dated 08/09/13, documented the resident was to receive acetaminophen 640 mg every four hours as needed for pain and Norco 5/326 mg two tablets every four hours as needed for pain. A routine pain medication was not ordered on readmission. A facility pain assessment was completed on 08/09/13, The assessment was completed on 08/09/13, The assessment was completed on 08/09/13, The assessment documented the resident had experienced pain daily in the last seven days in both legs and feet. The assessment revealed that pain was increased	PEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A BUILDIN 375034 B. WING	PERCENSION (X1) PROVIDERSUPPLIENCUA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING ST012 375024 B.WNG SOUDER OR SUPPLIEN STREET ADDRESS, CITY, STRIE, ZIP OC State State State State Street Street ADDRESS, CITY, STRIE, ZIP OC State State State State Street Street Street Street State State State State Street State State State Street State State State Street State State State Street State St	OPECHENCIENCES QC1) PROVIDERUPFUERCULA DENTIFICATION NUMBER: QC3 MULTIPLE CONSTRUCTION A BUILDING QC3 MULTIPLE CONSTRUCTION BUILDING QC3 MULTIPLE CONSTRUCTION BUILDING

CENTER	S FOR MEDICARE &	D HUMAN SERVICES				FORM OMB NO	0: 01/09/2014 APPROVED 0. 0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		SURVEY LETED
		375034	B. WING				17/2013
NAME OF PE	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 6202 EAST 61ST STREET		
MAPLEWO	OOD CARE CENTER				TULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of Deficiencies Y Must be preceded by full SC Identifying information)	ID PREF TAG	٦X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 157	A medication adminis 08/2013, documented Norco 5/325 mg, two On 08/24/13, the resi- non-healing pressure the facility on 09/16/1 The facility admission 09/16/13, documenter receive Norco 7.5/32 needed for pain and the receive Norco 7.5/32 needed for pain and the resident set of the resident for the resident set of the resident se	tration record, dated if the resident received tablets almost daily. dent was hospitalized for ulcers and re-admitted to 3. Vstart-up orders, dated d the resident was to 5 mg every four hours as haproxen 220 mg daily. ption on re-admission asure ulcers, multiple , and neuropathy. 109/16/13 at 1:46 p.m., arrived at facility via hospital ption on te-admission asure ulcers, multiple , and neuropathy. 109/16/13 at 1:46 p.m., arrived at facility via hospital ption on use to assess [and] th pain to allow nurse to turn back [and] coccyx" - vas completed on 09/16/13. umented the resident rated cale of one to ten. It was dent's pain was located in The pain was described as with activities. Int, dated 09/17/13, dent was on a scheduled men and received as needed a assessment revealed the requent and rated at six on a it was documented the pain	F	15			
	pain medication regin pain medication. The resident's pain was f	nen and received as needed e assessment revealed the requent and rated at six on a It was documented the pain					

Event ID: NU5U11

Facility ID: NH7228

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	01/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		MULTIPI. JILDING	ECONSTRUCTION		(X3) DATE & COMPL	URVEY
							c	
		375034	B. W.				12/1	7/2013
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
MADIEW	DOD CARE CENTER				6202 EAST 61ST STREET			
	SOD OARE CENTER				TULSA, OK 74138			1
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF	CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FUL		REFIX	(EACH CORRECTIVE ACT			DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATIO	N0	TAG	CROSS-REFERENCED TO T DEFICIENC		ALE	POIL
E 467	0		1				1	
F 157				F 15				1
		09/20/13, documented,			1		1	J
] in the building [new ord	er]		}			
{		to QID, Flexeril 10 mg	l					1
	TID"				{			
[On 10/02/12 the mail	dent was hospitalized fo	. 1				1	
		ulcers and re-admitted t						
	the facility on 10/08/1		.0				ļ	
{								1
	The diagnosis descri	ption on re-admission						
		erosis, depression, and	{				{	
		e low back, hip, and hee	. 1					
l					1			
	A pain assessment w	as completed on 10/08/1	3.					
ļ	The assessment reve	ealed the resident's						
	diagnosis of multiple	sclerosis and conditions	of					
1	contractures and pre	ssure ulcers that would I	ikely		1			
		ocumented the resident					1	
		as needed pain medical	ion.		{		1	
	It was also documen							
		s dull, burning, tingling, p			1			
}		ain involved both upper a	nd		1			
		curred dally, and was			1			
1	pain scale of one to	ensity was rated seven o	na l				1	
		positioning and moveme	n4))	
1	made the pain worse							
1	induo ino pain worse				4			
}	The facility resident-	data collection, dated						
{		ed the resident experience	bec		Í			
1		n in both lower extremitie			}			
	rating the pain a five	on a pain scale of one t	s l					
1	ten.		[
1								
1		ders, dated 10/2013,						
1		ident was to receive Alev	e		}			
		r pain. There was no	1					
1		y other pain medications			l			
	being ordered.							
FORM CMS-25	87(02-99) Previous Versions Of	osolete E	vent ID; NU5U11		Facility ID: NH7226	If contin	uation shee	Page 8 of 181

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL		CONSTRUCTION	(X3) DATE S COMPL	ETED
		375034	B. WING			C 12/1	7/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MARIEWO	OOD CARE CENTER			620	2 EAST 61ST STREET		
			~ ~ ~	TU	ILSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full LSC identifying information)	id PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page	98	F	157			
	200 mg one tablet ev	ders, dated 11/2013, dent was to receive Aleve ery day for pain and Norco ts every four hours as					
		m, dated 11/2013, dent received Norco 7.5/325 four hours as needed for					
	documented, "Prot monitor [sic] for any a if appropriateMedic call physician if no re medication as ordere and achieve her goa 4ApproachesIf re	alan, updated 11/25/13, olem/NeedShe will be and all pain, using pain scale bate with ordered medication elief obtainedGoalReceive adshe will be comfortable I of pain level elief is not obtained consult or add to medication					
	documented the resi 220 mg every day fo	iders, dated 12/2013, ident was to receive Aleve r pain and Norco 7.5/325 mg ir hours as needed for pain.					
	documented, "Nor Peg Tube Every 4 H a slash mark through	ions of the Norco, and the					
	through 12/09/13, re resident requested, 7.5/325 tablets with	ount sheets, dated 12/01/13 wealed documentation the on a daily basis, Norco each tube feeding, at 9:00	RIM		dilly ID: NH7226 If cont	inuation phone	t Page 9 of 181
FORM CMS-2	67(02-99) Previous Varsions Of	paojete Event (D, NU	0011	F80	diny by Min 220 If CON	nuation succ	ruada a ot.

ATEMENT	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED
		375034	B. WING				C 17/2013
NAME OF PR	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OD CARE CENTER			ł	202 EAST 61ST STREET ULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 157	Continued From page	9 9	F	157			
	a.m., 12:00 p.m., and						
		a.m., LPN #3 was observed re ulcer care to resident #3.					
	contracted in the hip torso was twisted to with both legs drawn	served to be severely s and knees. The resident's the left from the waist down and crossed at the ankies of in areas creating high risk					
	The LPN stated the r administered pain m the wound care begi	edication 30 minutes prior to					
	The resident was as scale of one to ten.	ked to rate her pain on a She stated, "Eight."					
	spasms. When the	able to refax due to muscle LPN would touch the begin having muscle spasms.					
		ion of the resident's lower ent would yell out, "Oh, Oh."					
	red, and her eyes we	ry flushed, her cheecks were ere wide. She had a grimace arful look when she knew I.					
		sident was asked if she had ation prior to wound care.					
	effective. She state	e felt the pain medication was d, "They tell me I take the cation they can give me, but I ser one "					

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Event ID: NU5U11

Facility ID; NH7226

If continuation sheet Page 10 of 181

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DAT	O. 0938 E SURVEY IPLETED
		375034	B. WING_			1	C 2/17/201:
	ROVIDER OR SUPPLIER			62	REET ADDRESS, CITY, STATE, 2IP CODE 202 EAST 61ST STREET JULSA, OK 74136	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 27 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	COMPL DAT
F 157	Continued From pag	e 10	F	157			
		e ever refused repositioning. nes. It hurts. They can't get					
	resident's pain medi administering wound	#2 was asked if she felt the cation was effective when I care. She stated, "She has n you touch or move her."					
		#2 was asked how she knew vain when administering care. ís."					
	resident was in pain the medication aide She stated the med pain pill. She stated	t she did when she saw the . She stated she would tell or reposition the resident. cation aide will give her a t, "She lets us move her but " She stated, "She hates					
	She was asked wha She stated, "Touchi	t causes the resident pain. ng and moving her."					
	resident's pain. She	she had told about the stated, "Everyone knows." e charge nurses were aware.					
	medication was effe	appeared the resident's pain ctive in relieving the e stated, "No, nothing					
	was responsible for	i a.m., LPN #2 was asked who resident #3's pain stated, "Dr. [name withheid]					

TATEMENTO	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DA	10.0938-039 TE SURVEY MPLETED
		375034	B. WING				C 2/17/2013
NAME OF PR	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP COD		2/11/2010
MAPLEWO	OOD CARE CENTER				AST 618T STREET A, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 157	Continued From page	e 11	F	157			
		was done with the during pain assessments. and medicate according to					
		caused resident #3 to have he has MS and is super					
	resident's pain during pain. She stated she resident had her pair assessed to see if it	she did to minimize the g activities known to cause a tried to make sure the n medication, and she worked. She stated the ain medication be given ding.					
	She was asked what medications were. S Baclofen, Neurontin.	the stated, "Norco and Aleve,					
	pain medication had "I don't know. As lot	h the last time the resident's been adjusted. She stated, ng as I been taking care of same." She stated she had ss than six months.					
		those specific medications tated, "I don't know."					
	that she was on the	the resident had been told strongest pain medication he stated, "I don't know who					
	administration record	D a.m., the medication d was reviewed It was ident had received Baclofen					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILLO		ONSTRUCTION	(X3) DATE S COMPL	ETED
		375034	B. WING			12/1	7/2013
NAME OF PR	OVIDER OR SUPPLIER			STR	REEY ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OD CARE CENTER				2 EAST 61ST STREET LSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X8) COMPLETION DATE
F 157	 7.5/325 mg at 9:00 a. On 12/13/13 at appro [name withheld] was him that the resident pressure ulcer dressi completely relieved d stated the resident's j completely relieved d stated that sometime resident could cause stated because of the pain was extremely d He was informed that medication was Aleve nothing." He was asked what f known the resident w with her pressure ulc would have increase He was asked if he d him of resident's pair He stated, "Yes I do, ears. I depend on th The physician was a someone had decrea needed Norco 7.5/32 four hours to one tab 	and one tablet of Norco m. ximately 9:50 a.m., Dr. asked if staff had informed had increased pain with ng treatment. He stated, ut that." The physician pain would never be ue to her diagnoses. He s, just breathing on the her excuciating pain. He a resident's diagnoses, her lifficult to manage. the resident's routine pain a. He stated, "That's he would have done if he had vas having increased pain er treatments. He stated, " I d her pain medication." hey are my eyes and my em."	F	157			
F 224 SS=E	"No,) don't." 483.13(c) PROHIBIT	•	F	224			
	67(02-99) Previous Varsions Ob	schote Eveni ID: NU5U	11	Faci	Illy ID: NH7226 If cont	nuation sheet	Page 13 of 181

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPI	
					1 0	;
		375034	B. WING		12/	7/2013
NAME OF PR	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER			202 EAST 618T STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION))D PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 224	Continued From Dage	13	F 224	F224		
r 224	The facility must deve policies and procedur mistreatment, neglec and misappropriation This REQUIREMENT by: Based on observation	elop and implement written res that prohibit t, and abuse of residents	F 224	1a. On 11/21/13, Re several items that wer missing were found and him. The additional it replaced on 1/16/14. 1b. On 12/14/13, resident plan was updated to reflect had a age progression of responds well to hand gest 2a. All residents have the	#30's care ect that she of 4yo and tures. he potential	1[21]]IL
	resident who was ob mistreated and failed of resident property f residents whose clini	to prohibit misappropriation or one (#14) of 29 sampled ical records were reviewed. at to affect 163 residents who		determine if any addition was missing or any allegations of abuse on 1/	ducted to nal property unreported 20/14.	
	care have an inherit physical, and mental and involuntary sector	esidents entrusted into our right to be free from verbal, l abuse, corporal punishment usion.		3. CNA #3 was in-serv Risk Manager nurse residents rights, dignity, on 12/19/13. All other st serviced on 1/20/14 by the 4. Random interviews with	regarding and abuse taff was in- e DON.	
	nor shail we tolerate our residents includi sexual, physical or n neglect, corporal pui resident funds or inv	y shall not use or condone, any form of abuse towards ng, but not limited to: verbal, nental abuse, mistreatment, nishment, misappropriation of oluntary seclusion"		and families to identi- items or abuse will be weekly $x \ 4$, monthly quarterly thereafter. Res- reported in the Quality	fy missing conducted x 3 and ults will be	
		s admitted to the facility on oses that included Alzheimer's		meeting.		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUL	TIPLE CO	DNSTRUCTION		10, 0938-0391 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILD			co	MPLETED
		375034	B, WING				C 2/17/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		2/1//2013
MAPLEW	DOD CARE CENTER				EAST MIST STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) Completion Date
F 224	08/20/13, documente t-shirts, 6 trousers, tw	d the resident had five to polo shirts, six pairs , two pajamas, and a mesh	F	224	-		
	09/26/13, documente the return of laundry. missingWhen aske often reappear. Whe meantime? This is e	d, "Biggest problem is with Too often items are d to look for things, they are were they in the specially true of there be some sort of					
		eting minutes, dated id, "Laundry occasionally sident. Please check more					
	documented, "Care and [family member is laundered by the fi on a frequent basis, returned, not knowin going" The form w	neeting form, dated 11/21/13, e plan meeting held c team and family member], clothing amily but clothing is missing States some things have g where they may be vas signed by RN #3, SS #2, and an unknown staff					
	was checked for clot and one t-shirt were	p.m., the resident's room hing. Two pajamas bottoms hanging in his closet. One ms and one t-shirt were h laundry basket.					
	missing clothing iten	a.m., the resident's asked if the resident had as. She stated, "Yes." She be had been resolved. She					

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014 APPROVED
		MEDICAID SERVICES					, 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE COMPI	ETED
		375034	B. WING	_		12/1	7/2013
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				6202 EAST 61ST STREET		
	SOB GARE GENTER			L	TULSA, OK 7413B		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	hasn't been resolved. found. They said the representative was as items were missing, replacing clothes even the family had taken the previous Saturdar only had one pants a The representative we reported the missing The representative si with staff just the pre- clothing items and the to file a complaint. T issue had also been meeting. On 12/16/13 at 8:34 was asked what she missing clothing duri stated she would rea missing items to the and if there was no re look for the missing it The MDS coordinato informed the adminis She stated she would stated there was an social services depar following through.	ay would take care of it, but it " She stated, "Some were y are working on it." The sked how many clothing She stated, "We have been ry week or so." She stated six new sets of clothing on y night because the resident nd one shirt left. The saked if they had items. She stated, "Yes." tated the family had talked vious day about the missing at they had been instructed he representative stated the brought up in the care plan a.m., MDS coordinator #2 did if a family complained of ng a care plan meeting. She issure them, report the housekeeping supervisor, esolution, she would go and	F	222			
	she was not aware o						

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CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES	Lorgan	Tire		FOR OMB NO	D: 01/09/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD		LE CONSTRUCTION	COM	E SURVEY PLETED C
		375034	B. WING				17/2013
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION BHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 224	Continued From page services.	9 16	F	22	24		
	asked what he did wh of missing clothing. I laundry. Do your bes	a.m., social services #2 was nen he received complaints He stated, *Talk with the it to track down the clothes. stated, "I have gone to the					
	the administrator of a stated, "Bring it to he #2 was asked what the stated what the statement of the statem	as asked how he Informed ny missing items. He r attention." Social services he administrator would do. missing items would have ministrator.					
		as asked if the resident's d of missing clothing items. member."					
	member was asked i missing clothing item lot." She was asked stated she had told v it was identified item	a.m., the resident's family f the resident had any is. She stated, "Yes, quite a if it had been reported. She whoever the nurse was when s were missing and the she had also addressed the olan meeting.					
	been addressed to h "I was told they were outside source [for la	was asked if the issue had er satisfaction. She stated, either in the laundry or the aundry]." She stated, "Stuff om the very beginning. A few low and then."					
	clothing on the previ	was asked if she brought new ous Saturday. She stated, I brought six pants and					

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Fadility ID: NH7226

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CENTER		D HUMAN SERVICES	077101	715		FOR OMB N	D: 01/09/2014 MAPPROVED D. 0938-0391 E SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD		9	COM	PLETED
		375034	B. WING	_			17/2013
NAME OF PE	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	matching shirts on Sa she had laundry now. of pants and shirts." On 12/16/13 at 9:27 a who did the resident's family." She was ask were complaints of m "Normally go to the h what she would do if in their room, CNA #' go to the rack in the I On 12/16/13 at 9:28 i observed to have five drawer. There were resident's closet. On 12/16/13 at 9:48 supervisor was aske received complaints She stated she would aide, do closet searce outside laundry compl The housekeeping s received complaints being missing. She stated the facility did but the aides put it in She stated, "You new they're not going to s supervisor stated sig always make a differ "Sometimes it will re	turday." She was asked if She stated, "Yes, two pair a.m., CNA #15 was asked a laundry. She stated, "The ed what she did when there issing laundry. She stated, ousekeeper." When asked the resident had no clothes 15 stated she would normally aundry and get some. a.m., the resident was a sets of clothing in his no clothes hanging in the a.m., the housekeeping d what she did when she about missing clothing items, d go straight to the laundry hes, and speak with the bany. upervisor was asked if she about the resident's clothing stated, "All the time." She not do the resident's laundry the laundry bins anyway. wer know who's doing it and say." The housekeeping ins were posted but it did not	F	222			
	she was told to do w	hen she reported missing trator. She stated, "All I can					

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CENTER	S FOR MEDICARE &	D HUMAN SERVICES				OM!	NTED: 01/09/2014 ORM APPROVED 3 NO. 0938-0391
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		3		DATE SURVEY COMPLETED C
		375034	B. WING				12/17/2013
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref TAG	٩X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XB) COMPLETION DATE
F 224	do is tell her and they the closets." She wa the administrator spe clothing items belong stated, "No." On 12/16/13 at 10:13 asked how staff notific complaints of missing would send an email they talked about it in The administrator wa the laundry be onsure She stated the clothin She stated, "[Laundry the laundry people." take care of." The administrator wa complaints regarding stated, "Try to find it. not, replace it." The administrator wa complaints of the res missing. She stated, 2. Resident #30 was 06/20/13 with diagno disabilities. The resident's care p documented, "is ap in or initiate conversi and grunts and this to has dx of mental reta depression/anxiety.	Just say to go look through s asked if she had Informed cifically about the missing ing to resident #14. She s a.m., the administrator was ed her if there were g laundry. She stated they or communication form and morning meetings. Is asked how she monitored residents got their clothes, ng was supposed to marked, y supervisor] and I check on Any Issues that come up we as asked how she handled missing laundry. She Sometimes it turns up. If as asked had there been ident's clothing being "Just once." a admitted to the facility on ases that included intellectual blan, dated 06/20/13, ohasic and cannot participate ation. She yells, screams upsets other residents. She	F	222			

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) M(8')		CONSTRUCTION	(X3) DATE	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI			COMPL	
						(c	:
		375034	B. WING			12/1	7/2013
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				02 EAST 61ST STREET ULSA, OK 74136		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETION DATE
F 224	respond to 1:1 interve "will receive medica minimize her risk for mood changes thru n included, "Observe ability to control beha needs and feelings may precipitate probl approach when inapp exhibited" On 12/09/13 at 3:31 were observed havin dining room. They w resident #30. Reside having verbal behavi the resident, and stat	antion" The goal was, ations as ordered and increase in behaviors or text review" Approaches behavior pattern. Watch for word and expressions of Recognize stressors that em behaviorUse calm propriate behavior is p.m., CNA #3 and SS #2 g a conversation in the north ere standing in front of ent #30 was yelling out and ors. CNA #3 turned, faced ted, "Shush."	F	224			
	#3 tell the resident to was standing right th shush before."	was asked if he heard CNA o shush. He stated, "Yes. I here. I've never heard that ministrator was asked if any allegation of verbal					
F 225 SS=E	mistreatment to her "No." 483.13(c)(1)(ii)-(iii), ((hat afternoon, She stated, (c)(2) - (4) ORT	F	225	1a. The abuse allegation for 1 #30 was reported to	the	سابط
	been found guilty of mistreating residents	employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide			Administrator by the surveyor accused CNA was place immediately suspension un completion of the investigation	ed on til the	

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PLAN OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	OMB NO (X3) DATE COMPI	SURVEY
	375034	B. WNG			0	; 17/20 1 3
ME OF PROVIDER OR SUPPLIER	1		s	TREET ADDRESS, CITY, STATE, ZIP CODE	14	112013
				202 EAST 61ST STREET		
APLEWOOD CARE CENTER				ULSA, OK 74136		
REFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
of residents or misa and report any know court of law against indicate unfitness fo other facility staff to or licensing authorit The facility must end involving mistreatment including injuries of misappropriation of immediately to the at to other officials in at through established State survey and ce The facility must ha violations are thorous prevent further pote investigation is in pu The results of all im to the administrator representative and with State law (inclu certification agency incident, and if the appropriate correct This REQUIREMEN by: Based on observal review, it was deter	abuse, neglect, mistreatment ppropriation of their property; viedge it has of actions by a an employee, which would r service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the ritification agency). ve evidence that all alleged ughly investigated, and must ntial abuse while the rogress. vestigations must be reported	F	225	 1b. A grievance form was confor Resident #14 regarding missing clothing and an investinitiated on 11/21/13. 1c. Resident #24 no longer residents facility. Resident #34 has a further injuries of un origin. Resident #21 has a further complaints of mistreath and interviews were conducted identify any other resident and interviews were conducted identify any other resident complaints of mistreatme injuries of unknown origin/20/14. 3. All staff was in-surgarding resident rights, or abuse and misappropriation property on 1/3/14. 4. Random interviews with reand families to identify ritems or abuse will be conweckly x 4, monthly x quarterly thereafter. Results reported in the Quality Astronomy and the property of the property of	igation ides in as had known ad no nent. ntial to family d to s with nt or in on erviced lignity, on of sidents nissing ducted 3 and will be	

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		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(° °		ECONSTRUCTION	(X3) DATE: COMPL	ETED
		375034	B. WING			12/1	7/2013
NAME OF PR	ROWDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER				202 EAST 61ST STREET TULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 225		e 21 be verbaily mistreated;	F	225			
	Investigate allegation resident property for	inistrator and thoroughly s of misappropriation of one (#14) of 25 sampled eviewed for misappropriation					
	related to resident to						
	This had the potentia resided at the facility	l to affect 163 residents who					
	Findings:						
	care have an Inherit	asidents entrusted into our right to be free from verbal, abuse, corporal punishment					
	nor shall we tolerate our residents includin sexual, physical or m	y shall not use or condone, any form of abuse towards ng, but not limited to: verbal, nental abuse, mistreatment, nishment, misappropriation of oluntary seclusion					
	of employment and t through the year on prohibition practices	a will be orientated at the time have on-going in-services issues related to abuse how staff should report ted to allegations without fear					

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Facility ID: NH7226

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		D HUMAN SERVICES				FO	ED: 01/09/2014 RM APPROVED NO, 0938-0391
STATEMENT	of deficiencies correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(ULT)Pi ILDING	LE CONSTRUCTION		TE SURVEY MPLETED
	1	375034	B, W	NG			C 2/17/2013
NAME OF PI	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP C		
MAPLEWO	OOD CARE GENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID	SI MANADY ST	ATEMENT OF DEFICIENCIES		10	PROVIDER'S PLAN OF	CORRECTION	(X6)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		REFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 225	Continued From page	22		F 22	5		
		ill provide to residents,		1 66			
	families and staff info	rmation on how and to					
	whom they may repo include the following:	rt concernsThis may					
		ring of residents with needs					
		might lead to conflict or	(
		idents with communication require heavy nursing care					
	and/or are totally dep						
	Investigation: facility Investigation and doc	will conduct a thorough cument all findings"					
		admitted to the facility on ses that included Alzheimer's					
	08/20/13, documente t-shirts, 6 trousers, tv socks, six underweat	belongings list, dated ad the resident had five vo polo shirts, six pairs r, two pajamas, and a mesh					
		neeting form, dated 11/21/13,					
	and [family member is laundered by the f	a plan meeting held c team and family member], clothing amily but clothing is missing					
{		States some things have g where they may be	1		4		
1	going " The form w	as signed by RN #3, SS #2,					
ł	the family members, member.	and an unknown staff					
l							
	was checked for clot and one t-shirt were	p.m., the resident's room hing. Two pajamas bottoms hanging in his closet. One					
	observed in the mes	ms and one t-shirt were h laundry basket.					
FORM CMS-28	67(02-09) Previous Versions Ob	solete Event ID.	NU5U11		Facility ID: NH7228	if continuation s	heet Page 23 of 181

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		375034	B. WING			12/	; 17/2013
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER			۱.	6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	Æ	(X5) COMPLETION DATE
F 225	On 12/16/13 at 8:15 a representative was as missing clothing item was asked if the issue stated, "They said the hasn't been resolved, found. They said the representative was as items were missing. replacing clothes eve the family had taken the previous Saturda only had one pants a The representative w reported the missing The representative st with staff just the pre- clothing items and th to file a complaint. T issue had also been meeting. On 12/16/13 at 8:34 was asked what she missing clothing duri stated she would rea missing items to the and if there was no n look for the missing it The MDS coordinato informed the adminis She stated she would stated there was a m	a.m., the resident's sked if the resident had s. She stated, "Yes." She be had been resolved. She by would take care of it, but it " She stated, "Some were y are working on it." The sked how many clothing She stated, "We have been ny week or so." She stated six new sets of clothing on y night because the resident nd one shirt left. The sked if they had items. She stated, "Yes." tated the family had talked vious day about the missing at they had been Instructed he representative stated the brought up in the care plan a.m., MDS coordinator #2 did if a family complained of ng a care plan meeting. She ssure them, report the housekeeping supervisor, esolution, she would go and	F	22	25		

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; NU5U11

Facility ID; NH7228

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		D HUMAN SERVICES				FORM	01/09/2014 APPROVED 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		375034	B. WING			C 12/1	7/2013
NAME OF P	NOVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADI SWI	OOD CARE CENTER			62	202 EAST 61ST STREET		1
	OD GARE GENTER			Т	ULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLD) CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) Completion Date
F 225	she was not aware of had, she would instru- services. On 12/16/13 at 8:49 a asked what he did wf of missing clothing. I laundry. Do your bes Try to find them." He laundry myself." Social services #2 was the administrator of a stated, "Bring it to he #2 was asked what ti He stated a list of the to be taken to the ad Social services #2 was family had complained He stated a list of the to be taken to the ad Social services #2 was family had complained He stated, "I don't rei On 12/16/13 at 9:16 member was asked stated she had told wit it was identified items laundry. She stated concern in the care p The family member w been addrassed to h "I was told they were outside source (for la has been missing fro	resident's family had g clothing items. She stated i that. She stated if they ct them to go to social a.m., social services #2 was een he received complaints de stated, "Talk with the st to track down the clothes. I stated, "I have gone to the as asked how he informed any missing items. He r attention." Social services he administrator would do. e missing items would have ministrator. as asked if the resident's ad of missing clothing items. member." a.m., the resident's family f the resident had any is. She stated, "Yes, quite a if it had been reported. She whoever the nurse was when s were missing and the she had also addressed the blan meeting. was asked if the issue had er satisfaction. She stated, e either in the laundry or the bundry]." She stated, "Stuff on the very beginning. A few	F	225			
		in the very beginning. A few					

Event ID: NU5U11

Feclility ID: NH7226

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/09/2014 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTU A. BUILDIN	IFLE CONSTRUCTION		LETED
		375034	B. WING		12/	; 17/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER			6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) Completion Date
F 225	Continued From page	ə 25	F 2	225		
	clothing on the previo "Yes." She stated, "I matching shirts on Sa she had laundry now of pants and shirts." On 12/16/13 at 9:27 who did the resident" family." She was asl were complaints of m "Normally go to the h what she would do if in their room, CNA# go to the rack in the On 12/16/13 at 9:28 observed to have five drawer. There were resident's closet. On 12/16/13 at 9:48 supervisor was aske received complaints She stated she would alde, do closet seard outside laundry com The housekeeping s received complaints being missing. She stated the facility did but the aides put it in She stated, "You ner they're not going to i supervisor stated sig always make a differ	upervisor was asked if she about the resident's clothing stated, "All the time." She not do the resident's laundry the laundry bins anyway. ver know who's doing it and say." The housekeeping ans were posted but it did not				

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Facility ID: NH7226

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		ID HUMAN SERVICES				FORM	01/09/2014 APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILDI		CONSTRUCTION	(X3) DATE & COMPL	ETED
		375034	B. WING			12/1	; 7/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE GENTER				02 EAST 61ST STREET JLSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID FREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	ə 26	F	225			
	she was told to do whitems to the administr do is tell her and they the closets." She wa	ipervisor was asked what nen she reported missing rator. She stated, "All I can / just say to go look through s asked if she had informed cifically about the missing					
	stated, "No."	ing to resident #14. She					
	asked how staff notific complaints of missing	g laundry. She stated they or communication form and					
	the laundry to ensure She stated the clothi She stated, "[Laundr	is asked how she monitored residents got their clothes, ng was supposed to marked, y supervisor] and I check on Any issues that come up we					
	complaints regarding	as asked how she handled missing laundry. She Sometimes it turns up. If					
	to dotte interesting the subject of the	as asked had there been sident's clothing being , "Just once,"					
		s admitted to the facility on uses that included Intellectual					
	documented, "is a	olan, dated 06/20/13, phasic and cannot participate ation. She yells, screams					

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES						01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES						0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CLIA QC2	2) MULTIPLE BUILDING	CONSTRUCTION		(X3) DATE S COMPLI	URVEY
		375034	B.1	WING			C	7/2013
NAME OF P	ROWDER OR SUPPLIER			5	TREET ADDRESS, CITY, STA	TE ZIE CODE	1 1211	
				1	202 EAST 61ST STREET			[
MAPLEWO	OD CARE CENTER				ULSA, OK 74136			(
	01114/10/07			- h				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRI EFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	e 27 psets other residents.	She	F 225				
	has dx of mental reta depression/anxiety. medication for this	rdation and She receives routine annot easily be redired	ted or					
	"will receive medica	ention" The goal was ations as ordered and increase in behaviors of						
	mood changes thru n	ext review" Approact behavior pattern. Wal	hes					
{	ability to control beha	wlor and expressions of Recognize stressors th	f				1	
	may precipitate probl approach when inapp exhibited"	em behaviorUse cair propriate behavior is	n					
	were observed havin dining room. They w	p.m., CNA #3 and SS # g a conversation in the ere standing in front of ent #30 was yelling out	north					
	All sensitive environments in a contrast of the second second second	ors. CNA #3 turned, fa						
	At 3:35 p.m., CNA # resident to shush. S	3 was asked if she told he stated, "No."	the					
	#3 tell the resident to	was asked if he heard (shush. He stated, "Ye ere. I've never heard t	es. I					
	one had reported an	ninistrator was asked it allegation of verbal that afternoon. She sta	1					
	documented, "[resi	ence report, dated 09/3 dent #34]bruising to came to this nurse, br bruising to chest"	[right]					
FORM CMS-25	67(02-99) Previous Versions Ob	elele	Event ID: NU5U11	F	acility ID: NH7226	If continu	ation sheet	Page 28 of 181

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/09/2014 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		375034	B. WING			12/4	7/2013
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		112010
				6	202 EAST 61ST STREET		
MAPLEW	OOD CARE CENTER				ULSA, OK 74138		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X8) COMPLETION DATE
F 225	Continued From page	9 28	F	225			
	incident between resi documented, "Bruis (resident #34)'s chesi white man with brown chair, [Resident #24] pulled back (like it is	sing (purple/blue) noted to t, she states that last night a n hair pushed her in her (is white with dark hair short). There are no white short). Residents separated, on 1:1 supervision,					
	she is ambulatory ad assistance with adi's. schizophrenia, psych depression. [Resider 1, she is up as tolera dependent on staff fo	nt #34] is alert and oriented x ted in a gerichair, she is or ali adi's. Her dx include: ior, depression, late effect					
	statement from employees were other employees were statement of the statem	nt investigation revealed a oyee #1 and a statement e was no documentation any re interviewed or that any embers were interviewed.					
	date of 10/04/13, doo has been transferred evaluation and treat	le incident report, with a fax cumented, "[Resident #24] to a behavlorai unit for nent. [Resident #34]: the complaints of pain"			•		
	nurse was asked if s	7 a.m., the quality assurance he had completed the jents #24 and #34. She					
FORM CMS-25	67(02-99) Previous Versions Ob	soleto Event ID: NU6U	11	F	acility ID; NH7228 if contin	uation sheet	Page 29 of 181

CENTER		D HUMAN SERVICES MEDICALD SERVICES	(X2) MUL	.	LE CONSTRUCTION	FORM	: 01/09/2014 APPROVED . 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				ETED
		375034	B, WING			1	17/2013
NAME OF F	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
F 225	The quality assurance had interviewed as presented interviewed as presented interviewed. She was asked interviewed. She start statements from all the transformer residents or fare interviewed. She start to review the investigg interviews had been the record and stated be in another folder and stated be in another folder and stated documentation." 4. Resident #21 was 09/08/13 with diagnor disorder. An incident report, di "This resident reports the investige of the investige of the investige of the record and stated be in another folder and the record and stated documentation." 4. Resident #21 was 09/08/13 with diagnor disorder. An incident report, di "This resident report, di "This resident report, di "This resident report, di nindependert c transfi in her w/c" A final incident report documented, "We substantiate this aller	a nurse was asked who she art of the investigation. She iewed resident #34 and the id how many staff had been ted there should have been ne aides on that shift. a nurse was asked if any nilly members had been ted, "Yes." She was asked ation and show where the documented. She reviewed if the documentation might and she would look. ality assurance nurse was nd any other documented ad, "I couldn't find any other a re-admitted to the facility on sees that included depressive ated 05/14/13, documented, if do a staff member that medication. When the nurse resident told her she was 1 reseald 'go to heil' and left has been suspendedThe j oriented. She is ters [and] self propelied [sic] t, dated 05/22/13, have been unable to gation. The nurse refused to o other residents had any	F	222			

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Facility ID: NH7226

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		MEDICAID SERVICES				1	0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE S COMPL	
			1 A BULLA	14G		0	
		\$75034	B. WING				7/2013
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OD CARE CENTER				102 EAST 61ST STREET ULSA, OK 74136		
(X4) /D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEF;CIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) Completion Date
F 225	Continued From page Review of the investig		F	225			
	documentation of res interviews.	ident, staff, or family					
	Review of staff roster longer employed at th	s revealed the nurse was no ne facility.					
	nurse was asked if si	a.m., the quality assurance he had completed the lent #21. She stated, "Yes."		,			
	had interviewed as p stated she had interv She was asked to rev show where the inter documented. She re	viewed the record and ation might be in another					
F 226	asked If she had four	ed, "I couldn't find any other	F	. 226	F226		
	ABUSE/NEGLECT, I	ETC POLICIES			1a. The abuse allegation for r	esident	hilu
	policies and procedu mistreatment, negled	elop and implement written res that prohibit x, and abuse of residents n of resident property.			#30 was reported to Administrator by the surveyo accused CNA was place immediately suspension un completion of the investigation	r, The ed on til the n	'Iə:(I4
	This REQUIREMEN	T is not met as evidenced			1b. A grievance form was con for Resident #14 regarding		

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CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TPLE	CONSTRUCTION	FORM	: 01/09/2014 APPROVED 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				COMPL	ETED
		375034	B. WING				, 17/2013
NAME OF P	ROVIDER OR SUPPLIER		1	(⁽	TREET ADDRESS, CITY, STATE, ZIP CODE		_
MAPLEW	OOD CARE CENTER				ulsa, ok 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 228	review, it was determ follow their abuse pol A. Staff did not repor mistreatment for one was observed to be v B. Staff failed to repor allegations of misapp property for one (#14 who were reviewed for property; and C. Staff failed to con related to resident to to resident verbal mis #24, and #34) of four investigations were r This had the potentia resided at the facility Findings: The facility's undated documented, "all ru care has an inherit ri physical, and mental and involuntary sector Therefore, this facility nor shall we tolerate our residents includi sexual, physical or n neglect, corporal pur resident funds or inv Training: employeed	Ined the facility falled to icy when: t an Incklent of verbal (#30) of one resident who verbally mistreated; ort and investigate ropriation of resident) of 25 sampled residents or misappropriation of duct thorough investigations resident abuse and/or staff atreatment for three (#21, residents whose abuse eviewed. It to affect 163 residents who sidents entrusted into our ght to be free from verbal, abuse, corporal punishment usion. y shall not use or condone, any form of abuse towards ng, but not limited to: verbal, nental abuse, mistreatment, nishment, misappropriation of	F	226	 1c. Resident #24 no longer rest this facility. Resident #34 h no further injuries of un origin. Resident #21 has h further complaints of mistreatm 2. All residents have the potenbe affected. Resident and interviews were conducted identify any other residents complaints of mistreatment injuries of unknown orig 1/20/14. 3. All staff was in-seregarding resident rights, or abuse and misappropriation property on 1/3/14. 4. Random interviews with reand families to identify ritems or abuse will be conweekly x 4, monthly x quarterly thereafter. Results reported in the Quality Assemeeting. 	as had known ad no nent. ntial to family d to s with nt or in on erviced lignity, on of sidents, nissing ducted, 3 and will be	

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Faolility ID: NH7226

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		D HUMAN SERVICES			PRINTED: FORM A OMB NO.	PPROVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	NG	(X3) DATE SU COMPLE	
		375034	B. WING_		C 12/17	/2013
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		
MAPLEW	OOD CARE CENTER			6202 EAST 61ST STREET TULSA, OK 74136		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A	CTION SHOULD BE	(X5) Completion Daye
F 228	through the year on la prohibition practices:, their knowledge relate of reprisal Prevention: facility w families and staff info whom they may repo include the following; planning, and monito and behaviors which neglect, such asres disorders, those that and/or are totally dep investigation: facility investigation: facility investigation: facility investigation and doo 1. Resident #14 was 08/20/13 with diagno disease. A resident personal to 08/20/13, documents t-shifts, 6 trousers, th socks, six underweat laundry basket. An interdisciplinary in documented, "Can and [family member is laundered by the f on a frequent basis, returned, not knowin going" The form w the family members, member.	ssues related to abuse how staff should report ed to allegations without fear fill provide to residents, imation on how and to tr concernsThis may assessment, care ring of residents with needs might lead to conflict or sidents with communication require heavy nursing care sendent on staff will conduct a thorough	F2	226		

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CENTE	TMENT OF HEALTH AN RS FOR MEDICARE &	MEDICAID SERVICES	- <u>1</u>		FORM OMB NO	: 01/09/2014 APPROVED . 0938-0391
	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		375034	B. WING			7/2013
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	NOOD CARE CENTER			6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFD TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 22	was checked for cloti and one t-shirt were i pair of pajama botton observed in the mesi On 12/16/13 at 8:15 representative was a missing clothing item was asked if the issu stated, "They said the representative was a items were missing. replacing clothes even the family had taken the previous Saturda only had one pants a The representative v reported the missing The representative sa with staff just the pre- clothing items and th to file a complaint. T issue had also been meeting. On 12/16/13 at 8:34 was asked what she missing clothing dur stated she would rear missing items to the and if there was no i look for the missing The MDS coordinate informed the admini	hing. Two pajamas bottoms hanging in his closet. One his and one t-shirt were halaundry basket. a.m., the resident's sked if the resident had s. She stated, "Yes." She e had been resolved. She ey would take care of it, but it " She stated, "Some were y are working on it." The sked how many clothing She stated, "We have been by week or so." She stated six new sets of clothing on y night because the resident ind one shirt left. was asked if they had items. She stated, "Yes." tated the family had talked vious day about the missing at they had been instructed the representative stated the brought up in the care plan a.m., MDS coordinator #2 did if a family complained of ing a care plan meeting. She issure them, report the housekeeping supervisor, resolution, she would go and	F 224			

Event (D; NUSU11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT (of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X8) DATE COMPI	SURVEY LETED
	-	376034	B. WING			12/	; [7/2013
NAME OF P	ROWDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER				202 EAST 61ST STREET		
	PI II B AL PM OF		1	1.	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page		F	226			
		write a statement. She eeting once a week and the					
		tment was good about					
	She was asked if the	resident's family had					
	complained of missin	g clothing items. She stated					
[f that. She stated if they lot them to go to social					
(services.						
	asked what he did wi of missing clothing. I laundry. Do your bes	a.m., social services #2 was then he received complaints He stated, "Talk with the st to track down the clothes. e stated, "I have gone to the					
	the administrator of a stated, "Bring it to he #2 was asked what to	as asked how he informed any missing items. He r attention." Social services he administrator would do. e missing items would have ministrator.					
		as asked if the resident's ad of missing clothing items. member."					
	member was asked missing clothing item lot." She was asked stated she had told w it was identified item	a.m., the resident's family if the resident had any us. She stated, "Yes, quite a lif it had been reported. She whoever the nurse was when s were missing and the she had also addressed the olan meeting.					
	The family member	was asked if the issue had					1

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Facility ID: NH7226

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		9		LETED
		375034	B. WING	_		12/	17/2013
NAME OF P	ROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	'IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	been addressed to he "I was told they were outside source [for la has been missing froi things will show up he "Yes." She stated, "I matching shirts on Si she had laundry now of pants and shirts." On 12/16/13 at 9:27 who did the resident" family." She was asl were complaints of m "Normaliy go to the h what she would do if In their room, CNA # go to the rack in the On 12/16/13 at 9:28 observed to have five drawer. There were resident's closet. On 12/16/13 at 9:48 supervisor was aske received complaints She stated she woul aide, do closet searc outside laundry com The housekeeping s received complaints being missing. She stated the facility did	er satisfaction. She stated, either in the laundry or the undry]." She stated, "Stuff m the very beginning. A few ow and then." vas asked if she brought new ous Saturday. She stated, brought six pants and aturday." She was asked if . She stated, "Yes, two pair a.m., CNA #15 was asked is laundry. She stated, "The red what she did when there hissing laundry. She stated, the resident had no clothes 15 stated she would normally laundry and get some. a.m., the resident was a sets of clothing in his no clothes hanging in the a.m., the housekeeping d what she did when she about missing clothing items. d go straight to the laundry thes, and speak with the	F	222			

Event ID: NU5U11

Facility ID: NH7228

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ATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED
		375034	B. WING_			1	C 2/17/2013
VAME OF P	ROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER		1		EAST 61ST BTREET SA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG	(PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AU DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	they're not going to s supervisor stated sig always make a differ "Sometimes it will read The housekeeping si she was told to do will items to the administ do is tell her and they the closets." She was the administrator spe clothing items belong stated, "No." On 12/16/13 at 10:13 asked how staff notif complaints of missin would send an email they talked about it it The administrator was the laundry to ensure She stated the cloth She stated, "[Laundi the laundry people. take care of." The administrator will complaints regarding stated, "Try to find it not, replace it." The administrator we complaints of the rea- missing. She stated	er know who's doing it and ay." The housekeeping ins were posted but it did not ence. She stated, cycle itself and get back." upervisor was asked what hen she reported missing rator. She stated, "All I can y just say to go look through is eaked if she had informed ocifically about the missing ging to resident #14. She 8 a.m., the administrator was led her if there were g laundry. She stated they or communication form and in morning meetings. as asked how she monitored a residents got their clothes. ing was supposed to marked. y supervisor] and I check on Any issues that come up we as asked how she handled g missing laundry. She . Sometimes it turns up. If as asked had there been sident's clothing being	F2	126			

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	01/09/2014 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	SLIA (X2	BUILDING	CONSTRUCTION		(X3) DATE S COMPLI	ETED
	3	375034	B.1	WING			C 12/17/2013	
NAME OF P	ROMDER OR SUPPLIER			8	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
MAPLEW	OOD CARE CENTER				202 EAST 61ST STREET			1
					ULSA, OK 74136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		id Prefix Tag	(EACH CORRECT) CRO6S-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X6) Completion Date
F 226	Continued From page	ə 37		F 226				
	Cisabilities.							
	The resident's care plan, dated 06/20/13, documented, "Is aphasic and cannot participate in or initiate conversation. She yells, screams							
		psets other residents.						
	depression/anxiety.	She receives routine						
		cannot easily be redired ention" The goal was						i
		ations as ordered and						
		Increase in behaviors of next review" Approact						
		behavior pattern. Wai						
		avior and expressions of Recognize stressors the stressor					1	
)		lem behaviorUse calr						
	approach when Inapper exhibited"	propriate behavior is						
		p.m., CNA #3 and SS #						
		ig a conversation in the vere standing in front of						
		ent #30 was yelling out						
	having verbal behavi the resident, and sta	iors. CNA #3 turned, fa ted, "Shush."	Iced					
	At 3:35 p.m., CNA # resident to shush. S	3 was asked if she told he stated, "No."	the					
		was asked if he heard						
		o shush. He stated, "Ye tere. I've never heard f						
	shush before."				1			
	At 4.25 p.m. the ed	ninistrator was asked it	anv					
	one had reported an		any					
		that afternoon. She sta	ited,					
FORM CMS-2	567(02-99) Previous Versions Ol	bsolete	Event ID: NU5U11	F	eclility ID: NH7228	If continu	ation sheet	Page 38 of 181

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY										
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COMPL	ETED			
		375034	B, WING			C 12/17/2013				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			1.000	REET ADDRESS, CITY, STATE, ZIP CODE					
MAPLEWO	DOD CARE CENTER				02 EAST 619T STREET ULSA, OK 74136					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIJ DEFICIENCY)		(X5) Comfletion Date			
F 226	Continued From page	38	न	226						
	date of 10/04/13, do has been transferred evaluation and treat	ole Incident report, with a fax cumented, "[Resident #24] I to a behavioral unit for nent. [Resident #34]: the o complaints of pain"								

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Event ID; NU5U11

Facility ID: NH7228

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		D HUMAN SERVICES				FORM	01/09/2014 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMPL	ETED
		375034	B. WING			12/1	; 7/2013
NAME OF P	ROMDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER			1	202 EAST 61ST 8TREET ULSA, OK 74138		
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IE I	(28) COMPLETION DATE
F 226	On 12/17/13 at 11:37 nurse was asked if si investigation for resid stated, "Yes." The quality assurance had interviewed as pa- stated she had interviewed. She sta statements from all the The quality assurance other residents or far interviewed. She sta to review the investig interviewed. She state to review the investig interviews had been the record and stated be in another folder at At 12:29 p.m., the qu asked if she had four interviews. She state documentation." 4. Resident #21 was 09/08/13 with diagno disorder. An Incident report, di "This resident report sheasked for pain brought them in, the 1/2 hrs late. The nur the room. Employee resident is alert [and	a.m., the quality assurance he had completed the lents #24 and #34. She e nurse was asked who she art of the Investigation. She iewed resident #34 and the bod how many staff had been ted there should have been he aides on that shift. e nurse was asked if any nily members had been ted, "Yes." She was asked lation and show where the documented. She reviewed d the documentation might and she would look. heality assurance nurse was head any other documented ed, "I couldn't find any other a re-admitted to the facility on see that Included depressive ated 05/14/13, documented, orted to a staff member that medication. When the nurse resident told her she was 1 rese said 'go to hell' and left e has been suspendedThe	F	226			

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Facility ID: NH7228

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II 7	PIEC	CONSTRUCTION	(X3) DATE 8	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI			COMPL	ETED
						C	
		375034	B. WING			12/1	7/2013
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				DE EAST 61ST STREET ILSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	id Prefi TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E I	(X5) Completion Date
F 226	give a statement. No complaints about the Review of the Investi- documentation of res- interviews. Review of staff roster longer employed at the On 12/17/13 at 11:37 nurse was asked if sl investigation for reside The quality assurance had interviewed as p stated she had interviewed as p stated the document folder and she would At 12:29 p.m., the qu asked if she had four interviews. She state documentation."	, dated 05/22/13, have been unable to pation. The nurse refused to o other residents had any nurse* gative file revealed no ident, staff, or family as revealed the nurse was no he facility. Ta.m., the quality assurance he had completed the dent #21. She stated, "Yes." the nurse was asked who she art of the investigation. She howed residents and staff. view the investigation and views had been howed the record and ation might be in another I look.		226	F241		
SS=E	manner and in an en	mote care for residents in a ivironment that maintains or ient's dignity and respect in or her individuality			1a. Resident #27, #30, #35, #3 #40 and #41 are asked each n by the CNA what time they get out of bed.	iorning	אוןובוי

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Event ID: NU5U11

Facility ID: NH7228

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014 APPROVED
		MEDICAID SERVICES					0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE (COMPL	
(375034	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADORESS, CITY, STATE, ZIP CODE	12/1	7/2013
					202 EAST 61ST STREET		
MAPLEW	OOD CARE CENTER				UL\$A, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	This REQUIREMENT by: Based on observatio	is not met as evidenced	F	241	1b. Residents #30, #31 and # now fed by a staff member remains seated throughout duration of the resident's meal.	r who t the	
	 review, it was determ A. (Treat seven (#27, and #41) of fifteen reformation of the seven (#27, and #41) of fifteen reside as being awakened the rebod beginning at 4:30 to affect fifteen reside as being awakened of B. Treat three (#30, residents who were of dignity during the dinidentified 17 resident eating. Findings: The facility's policy of documented, *Each in a manner that proof life, dignity, respectively. 	Ined the facility failed to: #30, #35, #37, #39, #40, sidents who were observed h dignity and respect when seidents and got them out of 0 a.m. This had the potential ants identified by the facility on the 11-7 shift; and #31, and #34) of eleven observed being fed with ing experience. The facility s as being dependent with n dignity, dated 10/2009, h resident shall be cared for motes and enhances quality ct and individuality			 1c. The dining room was c and cleared from the previous r 2. All residents who are dep during meals have the potentia affected. Dining room super were immediately notify to a any issues with dependent regarding dignity during meals 3. Nursing staff was inseregarding dignity during meals 3. Nursing staff was inseregarding dignity during meals 1/3/14. 4. Random audits of dining during and after meals w conducted weekly x 4, month and as needed. Results w reviewed in the Quality Ass Meeting. 	meal. endent l to be rvisors correct diners rviced als on ; room ill be ly x 3 rill be	
	respect at all times standards of care the prohibitedStaff sha residents with dignity The facility's policy of dated 10/2009, docu receive assistance w meets the individual residentResidents	n assistance with meals, mented, "Residents shall rith meals in a manner that					

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Event ID: NU5U11

Fadility ID: NH7226

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		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE (COMPL	ETED
		375034	B. WING			C 12/17/2013	
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	ODD CARE CENTER				9202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 241	 while assisting them who provide resident be trained and shall of the prevention of foor personal hygiene pra- handling" 1. On 12/09/13 at ap note titled 11-7 get-up on the southeast num list was resident #39, on the list. An 11-7 get up list wa located on the center named on the list. An 11-7 get up list wa located on the center named on the list. An 11-7 get up list wa located on the center named on the list. An 11-7 get up list wa located on the north wake resident #35, d bed. Seven addition the list. On 12/11/13 at 5: and #37 were observ in their chairs in the no fluids available to Resident #35 was ob with his eyes closed. On 12/11/13 at 6:25 what time she starter mornings. She state was asked if the resi stated, "Yes." 	Not standing over residents with mealsAl) employees assistance with meals will lemonstrate competency in fborne filness, including otices and safe food proximately 11:00 a.m., a b list was noted to be taped ses' station. Included on that Five resident names were as noted in the ADL book thall. Five residents were as noted in the ADL book hall. It was documented to ress him, and leave him in al resident names were on 10 a.m., residents #27, #30, red to be dressed and sitting north dining room. They had them.	F	24			

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Event ID: NUSU11

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	F DEFICIENCIES	MEDICAID SERVICES	CX20 MULT	PLECO	NSTRUCTION		(O. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				PLETED
							с
		375034	B, WING			1	2/17/2013
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER		ļ		EAST 61ST STREET SA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	Continued From page	- 43	F2	41			
		f bed. She stated, "5:00					
	and got her out of be She was asked if the	time she woke resident #27 d. She stated, "Around 5." resident was asleep when ut of bed. She stated,					
	#30 and got her out o 5." She was asked if	what time she woke resident of bed. She stated, "Around i the resident was asleep t her out of bed. She stated, eepy."					
	CNA #14 was asked to dress him. She st	if she had woke resident #35 ated, "Yes."					
	gotten up so early. S	why the residents were She stated it was so they reakfast on the 7-3 shift,					
	why staff started gett She stated, "That's a day shift doesn't hav getting them up." LF resident #35 was aw) a.m., LPN #4 was asked ling residents up so early. I good question. They say so e to come in here and start PN #4 was asked why akened, dressed, and left in					
	in the chair that long time breakfast was s 7:30 and 8:00 [a.m.].						
	for staff to get reside administrator stated,	a.m., the DON and sked what the reason was onts up so early. The "I wasn't aware they were early." They were asked					

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		MEDICAID SERVICES	1				0.0938-039
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		LETED
		375034	B. WING				C 17/2013
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER			100010	2 EAST 61ST STREET LSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XS) COMPLETION DATE
F 241	getting up so early. T social services talked asked them what time The administrator wa #30, and #37 could to get up that early. Sh The administrator am- resident #35 was dre bed. There was no c The administrator am- residents were not pr were taken to the din stated, "They should breakfast was served and 8:00 (a.m.)." 3. On 12/11/13 at 5. room was observed. warm juice, and cold cart in the dining roo The assisted feeding plates that contained These items were or menu. Resident #40 was of with her head resting She was asked if shi time. She stated, "N would rather be in be At 5:43 a.m., CNA # the dining room.	The administrator stated with the residents and a they would like to get up. a asked if residents #27, all staff they did not want to a stated, "No." d DON were asked why ssed at 4:30 a.m. and left in comment. d DON were asked why the rovided fluids when they ing. The administrator ' be." She was asked when a. She stated, "Between 7:30 05 a.m., the southeast dining Pitchers of warm water, coffee were observed on a	F	241			
		as asked if the staff got her					1

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		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLVA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		LETED
		375034	B. WING			C 12/17/2013	
NAME OF P	ROVIDER OR SUPPLIER		and the second sec		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER				8202 EAST 61ST STREET TULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(XB) Completion Date
F 241	up. She stated, "Yes. wanted to get up this She was asked if she She stated, "Yes." Si up early everyday. S At 6:00 a.m., resident wheelchair at a feedin The resident was talk At 6:18 a.m., LPN #1 #41 was up at 6:00 a, the get up list which r anytime after 5:00 a, comprised most of re assistance feeding. At 7:49 a.m., residen At 7:57 resident #41 4. On 12/09/13 at 12 noon meal in the nor CNA #4 began feedin as she fed the reside At 12:11 p.m., CNA # #34. She stood as s began feeding reside #31. She continued At 12:12 p.m., CNAs about personal issue dining room table wh	 " She was asked if she early. She stated, "No." would rather be in bed. he was asked if staff got her he stated, "Yes." t #41 was observed in a ng table in the dining room. ting to himself. was asked why resident .m. She stated he was on meant he was to be woke up m. She stated the list was isidents who required t #39 received her breakfast. t #39 received her breakfast. t #39 received her breakfast. 2:05 p.m., observations of the th dining room were made. ng resident #31. She stood ont. #8 began feeding resident he fed the resident. CNA #4 ent #30 as well as resident 	F	241			
EOPM CMR 25	67(02-99) Previous Versions Ot	xsolate Event ID: NU5			Facility ID: NH7226 (f cont	inuation shael	Page 48 of 181

			D HUMAN SERVICES			FORM	01/09/2014 APPROVED 0938-0391		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPL A. BUILDING		(X3) DATE S COMPLI	ETED		
			375034	B. WING		C 12/17/2013			
Γ	NAME OF PR	CVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	MAPLEWO	OD CARE CENTER							
	(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	TULBA, OK 74136 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE		
	F 241 85=E	dining rooms. The D licensed staff member monitor each dining r manager monitored a The DON and adminit the aides were support while feeding. The D residents." She was supposed to stand wi would be unable to s choking if they were a administrator stated, 483.15(e)(1) REASO OF NEEDS/PREFER A resident has the rig services in the facility accommodations of i preferences, except the individual or other endangered. This REQUIREMENt by: Based on observation determined the facility in a timely manner a accessible for four (f residents who were concerns. This had	a.m., the DON and sked who monitored the ON stated there was a in who was supposed to oom and the dietary cometimes. Instrator were asked where based to position themselves ON stated, "Next to the asked why the staff were not hile feeding. She stated staff be if the residents were standing up. The "It's a dignity issue." INABLE ACCOMMODATION RENCES ght to reside and receive y with reasonable ndividual needs and when the health or safety of in residents would be T is not met as evidenced on and interview, it was ty falled to answer call lights md/or ensure call lights were pt15, #18, #42, and #43) of 27 observed for call light the potential to affect 140 by the facility as being able to	F 24		/11/13 ssisted 3 call t was ghts d. All, ed. arding wwed nd as ing of	1/21/14		
		determined the facili in a timely manner a accessible for four (# residents who were concerns. This had residents identified b	ty failed to answer call lights nd/or ensure call lights were #15, #18, #42, and #43) of 27 observed for call light the potential to affect 140 by the facility as being able to		 1/3/14 by the DON regard promptly answering call lights. 4. Call light logs will be revieweekly x 4, monthly x 3 and needed to ensure timely answering 	arding wed nd as ing of iewed			

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Event ID: NU5U11

Facility ID: NH7226

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					01/09/2014 APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	-			OMB NO.	0938-0391
	of deficiencies correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE & COMPL	
		375034	B, WING			C 12/17/2013	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	DOD CARE CENTER			1	6202 EAST 61ST STREET		1
MAL FRAC	JOD OAKE CENTER			1	TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XT	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) Oompletion Date
F 246	The facility's policy ar Answering the Call Li documented, "Gene resident's call as sooi 1. Resident #18 was 11/18/13 with diagnos pressure ulcer and co On 12/11/13 at 5:03 a feces was noted from from the resident's ro The resident's light w entered the resident's "Ma'am, can you help to be changed out, at surveyor asked the re her call button for as: asked, "Where is it?" to be between the re upper side rall. It was The call light was giv pushed the button. The resident's gown and feces. The resident's feces was noted to c At 5:08 a.m., CNA # room. The resident's turned on the light. I the juncture of the re urinary catheter tubil colostomy bag was a and feces was noted	nd procedure titled ght, dated October 2010, eral guidelinesAnswer the n as possible" admitted to the facility on ses that included a stage III plostomy. a.m., a very strong smell of n the hallway to be coming orn. ras off and the surveyor is room. The resident asked, o me? My colostomy needs nd I can't do it." The asident if she had pushed sistance. The resident ' The call light was observed sident's mattress and the left is out of the resident's reach. ren to the resident, and she The resident was noted to ering her left hand. The bed linens were covered with is abdomen was exposed and over her abdomen. I entered the resident's informed the CNA she with her colostomy. CNA #1 Liquid feces was puddled in sident's legs. The resident's ng was in the feces. The expanded with air and feces, it to be draining between the	F	24			
	skin and the seal of	the colostomy bag.					

FORM CMS-2567(02-99) Previous Versions Obsoleta

Event ID: NU5U11

Facility ID: NH7226

If continuation sheet Page 48 of 181

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICADE SERVICES ONB NO. 0038-0391 STREEM MEDICATE SERVICES ONB NO. 0038-0391 STREEM OF DEFICIENCIES ONE NO. 0038-0391 NAP PLAN OF DEFICIENCIES ONE NO. 0038-0391 NAP PLAN OF DEFICIENCIES ONE NO. 0038-0391 MAPLEWOOD CARE CENTER STREET ADDRESS, GTV, STREET VALUE OF PROVIDER ON SUPPLIES BURNAMEY STREET TULEA, OK 74156 MAPLEWOOD CARE CENTER BURNAMEY STREET TULEA, OK 74156 PREX STREET ADDRESS, GTV, STREET TULEA, OK 74166 MAPLEWOOD CARE CENTER BURNAMEY STREET TULEA, OK 74156 PREX STREET ADDRESS, GTV, STREET TULEA, OK 7000000000 Street TULEA, OK 74156 F246 Continued From page 48 F 246 At approximately 5:10 a.m., CNA #1 was asked when the resident's acloside and the resident. She stated, "Every two hours." She was asked when the resident's acloside and the resident. She stated, "Every two hours." She stated 11:00 p.m. Sho was asked when ab empled the colostomy. F 246 On 12/17/13 at 2:39 p.m., the DON was stated at the baging and no lock the reall light resch." Con 12/16/13 at 4:01 p.m., the ADON was noted to be sitting at the north nurse' station. She was alked when abe empled the deak. The call light continued to go off. At 4:00 p.m., MDS coordinator #1 was observed waking own the noth the all, note or the call light to make down the hall, noted beped and asasted resident #44 off two heal light tor.		MENT OF HEALTH AN					F		01/09/2014
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At 4:06 p.m., an unidentified CNA was observed to walk down the hall, notice the call light for	l I		d seated at the nurses'						
to walk down the hall, notice the call light for	1	station.				{			
to walk down the hall, notice the call light for	1	At 400 mm	hantified CNIA was ab-	-		{			
						}			
				Event ID: NU5U11		Facility ID: NH7226	H		Dama 40 -147

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	S FOR MEDICARE &						NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI		DNSTRUCTION		ATE SURVEY
	i	375034	B. WING				C 12/17/2013
AME OF PE	ROVIDER OR SUPPLIER		-	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
APLEWO	DOD CARE CENTER				2 EAST 615T STREET SA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XB) COMPLETIO DATE
F 246	Continued From page	ə 49	F	246			
		er the room to assist the					
At 4:07 p.m., the ADON was asked what her title was. She stated she was the ADON. She was asked how staff would know if call lights ware going off. She picked up a pager off the desk and stated there was a pager system for call lights. As she picked up the pager, it beeped. The ADON was asked if she was aware that while sitting at the nurses' station, three call lights had been going off. She stated, "No, I wasn't. I was looking at a chart." On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." She was							
	located. She stated,	its were supposed to be "Within residents' reach."					
	The DON was asked how staff knew if a call light had been activated. She stated the facility used a pager system and through observations. The DON was asked what her expectation was for all staff members if a call light was noted to be going off. She stated, "Any staff member is supposed to answer the lights."						
	08/09/13 with diagno	s admitted to the facility on uses that included multiple In, muscular disuse atrophy, stomy.					
	"Problem/ NeedADLsHas d	l 08/09/13, documented, ix of MS and is extensive or sApproachesCall light					

FORM CM8-2567(02-99) Previous Versions Obsolete

Event ID; NU5U11

Facility ID: NH7226

If continuation sheet Page 50 of 181

		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	LETED
		375034	B. WING			12/	17/2013
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER				202 EAST 61ST STREET ULSA, OK 74136		Į
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	jd Prefi Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	Continued From page	a 50	F	246			
		lent was cognitively intact indent on staff for transfers,					
	knocked on resident came on. When the resident was sitting in	o.m., when the surveyor #15's door, her cail light surveyor entered, the I her wheelchair next to her had just turned her cail light					
		ed how long it usually took r call light. She stated, "20 imes over an hour."					
	to meet her needs. S full to the max and th the center hall and th	e feit there was enough staff She stated, "No, this place is ere are only three people for is frail." She stated, "it's gs is always short staffed."					
	room and asked, "[N	N entered resident #15's ame withheld] you need sident stated, "I Just wanted					
	It was observed that respond to resident #	it took 51 minutes for staff to #15's call light.					
		p.m., the DON was asked Il light response time was. eight minutes."					
	had been activated. pager system and th	I how staff knew if a call light She stated the facility used a rough observations. The at her expectation was for all					

FORM CMS-2587(02-89) Previous Versions Obsoleto

Event ID NU5U11

Facility ID: NH7228

If continuation sheet Page 51 of 181

ATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
		B-7FAA/	B. WING			2
	ROMDER OR SUPPLIER	375034		STREET ADDRESS, CITY, STATE, ZIP CODE		17/2013
WALL OF FI	KOWDER OR SUPPLIER			6202 EAST 619T STREET		
MAPLEW	DOD CARE CENTER			TULSA, OK 74138		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENT(FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X3) Completion Date
F 246	off. She stated, "Any to answer the lights." The DON was asked answer the call light f stated, "I do not know monitored to ensure timely. She stated sh	I light was noted to be going staff member is supposed why it took 50 minutes to or resident #15. She ." She was asked how she call lights were answered he audited the call light logs	F 24	6		
F 274 SS=D	same residents who 483.20(b)(2)(ii) COM AFTER SIGN/FICAN A facility must condu- assessment of a resi- facility determines, or that there has been a resident's physical or purpose of this section means a major declin resident's status that itself without further it implementing standa Interventions, that has one area of the resid requires interdiscipilin care plan, or both.) This REQUIREMENT	PREHENSIVE ASSESS T CHANGE	F 27	Resident # 1 on 12/17/13 2. All residents with a s change in staus have the be affected. A rev residents within the identify resident with changes was completed of 3. MDS coordinators w serviced on 12/20/13 by of Clinical Reimbursement significant change in stat 4. Audits will be compl ensure that significant	npleted on significant e potential to iew of the facility to significant on 12/17/13. ere in the Director ent regarding tus criteria. leted to thange in	
	by: Based on interview determined the facili significant change as sampled residents w reviewed. This had	and record review, it was ty failed to complete a sessment for one (#1) of 29 hose assessments were the potential to affect 163 id at the facility. Findings:		status assessments are when indicated weekly x 3 and as needed. Re reviewed in the Qualit Meeting.	e completed x 4, monthly sults will be	

FORM CM8-2567(02-99) Previous Versions Obsolete

Event ID: NU5U11

Facility ID: NH7226

if continuation sheet Page 52 of 181

		MEDICAID SERVICES					VO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILD	NG			te survey Mpleted
		375034	B. WING				C 2/17/2013
AME OF PF	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD		21112010
APLEWO	OOD GARE CENTER				ST 61ST STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Completic) Date
F 274	Continued From page	ə 52	F	274			
		nitted to the facility on ses that included respiratory osteoarthritis.					
		l record revealed sident had been re-admitted 1/13 following hospitalization					
	documented, "Res s [oxygen] on. She]	1 11/07/13 at 8:00 p.m., [up] walking by nurses' desk ost her balance and fell into onto floor. res c/o pain hip*					
		d 11/15/13 at 4:00 p.m., returned to facility o [left] hip					
	significant change as completed for the re-	sident after having a t hospital stay and a fall with					
	was asked if the rest sustained a hip fract yes. She was asked hospitalized during (a.m., MDS Coordinator #1 ident had suffered a fall and ure on 11/07/13. She stated I if the resident had been October due to a psychiatric i yes. She was asked if a					
	significant change a completed for the re MDS Coordinator #1 been done."	ssessment had been sident. She stated, "No." i stated, "One should have					
F 278	483.20(g) - (j) ASSE ACCURACY/COOR	SSMENT	F	278			

i

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		LETED
		375034	B. WING			12/) 17/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BEADI CINI	OOD CARE CENTER		1	62	202 EAST 61ST STREET		1
INAPLEW	JUD LARE CENTER			T	ULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) DOMPLETION DATE
F 278	Continued From page	ə 53	F	278	F278		
	The assessment mus resident's status.	t accurately reflect the			1. A modification to resident #16 and #1s MDS was comple 12/16/13.	ted on-	12114
	A registered nurse mi each assessment wit participation of health				 All residents have the potentiate to be affected. MDS were rev 		
		ust sign and certify that the			to ensure that coding was accur 01/16/14. 3. MDS coordinators were in	ate on	
	The second state of the second	completes a portion of the in and certify the accuracy of sessment.			serviced on 12/20/13 by the Di of Clinical Reimbursement reg MDS coding.		
	willfully and knowing false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowing to certify a material a resident assessment	Inder Medicare and Medicaid, an individual who villfully and knowingly certifies a material and alse statement in a resident assessment is ubject to a civil money penalty of not more than 11,000 for each assessment, or an individual who villfully and knowingly causes another individual to certify a material and false statement in a esident assessment is subject to a civil money venalty of not more than \$5,000 for each			4. Audits will be conducted to ensure that MDS's are accurately weekly x 4, month and as needed. Results w reviewed in the Quality Asso Meeting.	coded ly x 3 ill be	
	Clinical disagreemen material and false stu	it does not constitute a atement.					
	by: Based on observation review, it was determ ensure assessments wounds and antipsyon and #16) of 29 samp assessments were m	T is not met as evidenced on, interview, and record nined the facility failed to were accurate related to chotic medications for two (#1 bled residents whose eviewed. This had the 3 residents who resided at					

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NU5U11

Facility ID; NH7226

If continuation sheet Page 54 of 181

		D HUMAN SERVICES					FORM	: 01/09/2014 APPROVED . 0938-0391
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION		(X3) DATE (COMPL	ETED
		375034	B. WING	_			12/1	7/2013
NAME OF PR	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE,	ZIP CODE		
MAPLEWO	ODD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136			
	PLANADY OT	ATEMENT OF DEFICIENCIES	1 10	1		N OF CORRECTION	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD B		(XS) COMPLETION DATE
F 278	Continued From page	• 54	F	27	8			
	the facility. Findings:		1					
	10/02/13 with diagnos	admitted to the facility on ses that included lower limb bipolar disease, and chronic						
	10/11/13, documente	slon assessment, dated d the resident was did not have any skin						
	dated 10/11/13, docu wound causes are un obtained from the [fai resident had surgery	orksheet on pressure ulcers, mented, "Resident's iknown at this time. History mily member] stated that and follow up care was not foes not appear to be the where wounds are						
	the surveyor three w) p.m., the resident showed ounds on her lateral right stated the wounds were due blowing surgery.						
	was why it was docu skin conditions. She and stated the wound	5 a.m., the MDS Coordinator mented the resident had no reviewed the assessment ds should have been coded . She stated the assessment would be fixed.						
	2. Resident #1 was 10/01/13 with diagno depression.	re-admitted to the facility on ises that included						
	Admission orders, da the resident was to r	ated 10/01/13, documented acelve Abilify, an						

FDRM CMS-2587(02-69) Previous Versione Obsolete

Event ID: NU5U11

Facility ID: NH7226

If continuation sheet Page 55 of 181

	FDEFICIENCIES	MEDICAID SERVICES	Avent BALE TIP			0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE : COMPL	
			The bolt bing			1
		375034	B. WING		1	, 17/2013
NAME OF PR	OVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		172010
				6202 EAST 61ST STREET		
MAPLEWO	DOD CARE CENTER			TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X8) COMFLETIO DATE
F 278	antipyschotic medical depression. MARs, dated 10/02/1	tion, 2.5 mg daily for	F 27	8		
	antipsychotic medica days. On 12/16/13 at 9:57 was asked how she r regarding medication the previous seven d orders." She was as was not identified on	ent, dated 10/03/13, dent did not receive any tilons in the previous seven a.m., MDS Coordinator #1 received the information is the resident took during lays. She stated, "From the ked why the use of Abilify the resident's assessment. zero and it should have been				
F 279 SS=D	COMPREHENSIVE A facility must use th to develop, review an comprehensive plan The facility must dev plan for each resider objectives and timeta medical, nursing, an needs that are identi assessment. The care plan must to be furnished to att highest practicable p	CARE PLANS le results of the assessment nd revise the resident's	F 21	 F279 1a. Resident #1 care updated on 12/16/13 antipsychotic use. 2. All residents have the be affected. Audit will current residents care plan they are accurate and residents' current plan 01/16/14. 3. MDS was in-service Director of Clinical Reir regarding updating care on 12/20/13. 	to reflect potential to be done of as to ensure reflect the of care by ed by the nbursement	

FORM CMS-2587(02-89) Previous Versions Obsolete

Event ID; NU5U11

Facility ID: NH7228

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		ID HUMAN SERVICES			FORM	: 01/09/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE Comp	SURVEY LETED
		375034	B. WING_			C 17/2013
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZI		
MAPLEW	OOD CARE CENTER			0202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(265) COMPLETION DATE
F 279	be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on Interview a determined the facilit comprehensive care of anxiety and the us medications for one (whose care plans we potential to affect 160 the facility. Findings Resident #1 was re- 10/01/13 with diagno depression. Admission orders, da the resident was to re antipyschotic medica depression. It was also document receive Ativan, an ar for anxlety. Review of the reside 12/05/13, revealed in was no goal, and the was only documente Ativan for anxlety. There was no proble	vices that would otherwise 83,25 but are not provided exercise of rights under e right to refuse treatment If is not met as evidenced and record review, it was y failed to develop plans related to a diagnosis e of antipsychotic (#1) of 29 sampled residents are reviewed. This had the 3 residents who resided at to the facility on sees that included	F2	4. Random audits o be done by DON/de 4 weeks, then mor quarterly to ensu accurately reflect current plan of care be reported through	signee weekly X nthly X 3, then re care plans the residents & findings will	

FORM CM9-2567(02-69) Previous Versions Obsolete

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Event ID: NU5U11

Fedility ID: NH7226

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		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/SLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	FORM OMB NO E CONSTRUCTION (X3) DATE	0: 01/09/2014 APPROVED 0. 0938-0391 SURVEY LETED
	ROVIDER OR SUPPLIER	376034	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 8202 EAST 61ST STREET	C 17/2013
(X4) 1D PREFIX TAG	SUMMARY ST. (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	TULSA, OK 74136 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(205) COMPLETION DATE
F 279 F 280 SS=D	was asked why fhe u identified as a proble plan, with goals and i stated, "I don't have a MDS coordinator #2" not identified as a pro- plan, with goals and i use of Ativan, Identifi We'll double check fr 483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or other incapacitated under participate in plannin changes in care and A comprehensive as interdisciplinary team physician, a register for the resident, and disciplines as determ and, to the extent pr the resident, the resi legal representative;	ntions. a.m., MDS coordinator #2 se of Abilify was not m on the resident's care interventions identified. She an answer." was asked why anxiety was bblem on the resident's care interventions, including the ed. She stated, "I'II fix it. om now on." (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and freatment or treatment. re plan must be developed	F 28	H280	

FORM CMS-2587(02-98) Previous Versione Obsciele

Event ID: NU5U11

Fecliky ID: NH7226

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		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		375034	B. WING			12/1	, 17/2013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	DOD CARE CENTER			L	6202 EAST 61ST STREET TULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 280	This REQUIREMENT by: Based on observatio review, it was determ update a care plan to approaches related to (#15) of four sampled whose care plans we identified eight reside Findings: The facility's policy at colostomy/leostomy documented, "Purp procedure is to provik preventing exposure matter" Resident #15 was ad 08/09/13 with diagno sclerosis, muscular d and colostomy. The resident's care p documented, "Prob without difficultySki The approaches did colostomy bag after and cilipping the end leakage of feces onto to maintain skin integ A facility form, labele	is not met as evidenced n, interview, and record ined the facility failed to have resident-specific o colostomy care for one residents with colostomies re reviewed . The facility ints as having colostomies. Ind procedure on Care, dated October 2010, ose The purpose of this de guidelines that will aid in of the resident's skin to fecal imitted to the facility on ses that included multiple lisuse atrophy, paraplegia, Nan, dated 08/09/13, olemColostomy functioning in intact" not include rinsing the emptying or proper folding of the bag to prevent o the resident's skin in order grity. d skin and dated 10/10/13, pstomy care [every] shift per : 7-3; 3-11; 11-7"	F	280	0		

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: NU5U11

Facility ID: NH7226

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED , 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ECONSTRUCTION	(X3) DATE I COMPL	BURVEY
		375034	B. WING			12/1) 17/2013
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	OD CARE CENTER			{ •	202 EAST 61ST STREET		
MAPLEYN	OU CARE CENTER			1	TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies Y Must be preceded by full .sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(45) Completion Date
F 280	and was totally depent toilet use, and bathing documented, "Appl On 12/18/13 at 2:33 (asked who was respondent colostomy bag. She She stated the staff of bag after emptying it, used a "baby wipe" to bag. At 2:45 p.m., residen observed to have a n stool and air in the ba a copious amount of bag to the very end w and olipped. Approx of the bag was expose end that had been le cleansed of feces. T together with dried fe She was asked if the folded once with the after staff has emptifie had it drip down my is got on her clothes. On 12/17/13 at 9:18 what training the CM	dent was cognitively intact indent on staff for transfer, g. Bowel continence lances: ostomy" o.m., resident #15 was onsible for emptying her stated, "A lot of them try." lid not rinse the colostomy She stated staff sometimes to clean inside the end of the t #15's colostomy bag was noderate amount of formed ag. The colostomy bag had feces lining the inside of the which was folded over once imately one inch of the end sed past the clip. The bag's ff exposed had not been the bag's end was stuck	F	280			
F 282	colostomy bag. She rinse with soap and	they were taught to clean the stated, "We just know to water." VICES BY QUALIFIED	F	28	2		

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Event ID: NU6UH

Facility ID; NH7226

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT C	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ECONSTRUCTION		LETED
1		375034	B, WING			12/	C 17/2013
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				202 EAST 61ST STREET		
				יו	TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full LSC identifying information)	ID PREF TAC	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	Æ	(X5) Completion Date
•	must be provided by accordance with eac care. This REQUIREMENT by: Based on observation review, it was determ implement intervention plan related to pain, pressure ulcers for the sampled residents with reviewed. This had in residents who resides Findings: 1. Resident #3 was 09/14/11 with diagnot scienosis (MS), chron contractures, multipli and myalgia. The re- medications via a per- tube. Physicians orders, do the resident was to not two tablets every eig 10 mg every six hou Zanaflex 4 mg every	RE PLAN d or arranged by the facility qualified persons in h resident's written plan of T is not met as evidenced on, Interview, and record hined the facility failed to ors identified on the care colostomy care, and/or tree (#3, #12, and #18) of 25 hose care plans were the potential to affect 163 id at the facility.	Ĕ	282	F282	ensure were a each ntial to ced on- 7 the 1 /14 by will uly x 3 vill be	
		dated 02/08/13 at 7:00 p.m., ease the resident's Norco					

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID, NU5U11

Facility ID: NH7226

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	and a second	D HUMAN SERVICES					FORM	0: 01/09/2014 APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
[375034	B. WING			_		C 17/2013	
NAME OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, ST.	ATE, ZIP CODE			
MAPLEW	OOD CARE CENTER				202 EAST 618T STREET ULSA, OK 74136				
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be preceded by full .sc identifying information)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	BPLAN OF CORRECTIO CTIVE ACTION SHOULD NCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	 7.5/325 mg every eig A physician's order, of the resident could receivery eight hours as A nurse's note, dated [Name withheld] [com Norco does not reliev [it back to 2 tab [sic] A physician's order, of to increase the pain for pain. A quarterly assessme documented the resili required total assista mobility, transfers, and the pain for pain. 	ht hours for pain. Pated 02/17/13, documented perve Norco 7.5/325 mg needed for pain. 02/19/13, documented, " aplains of] pain[one] tab re painRequested to have " Pated 02/19/13, documented nedication back to Norco ts every eight hours routinely pent, dated 06/18/13, dent was cognitively intact, nce from staff for bed nd all ADLs. It was	F	282					
	extremity range of m joint contractures. An annual assessme documented the resi- pain medication regin needed pain medicat revealed the residen rated at six on a scal documented the pair resident to sleep. On 10/03/13, the resi non-healing pressure the facility on 10/08/ The diagnosis descri-	dent was on a scheduled men and received as tion. The assessment t's pain was frequent and te of one to ten. It was in made it hard for the ident was hospitalized for e ulcers and re-admitted to							

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Event ID; NU5U11

Facility ID: NH7226

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(XS) DATE COMPL	SURVEY
		375034	B.W	ING		120	C
NAME OF PR	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		11/2010
				6	202 EAST 61ST STREET		
MAPLEW	OOD CARE CENTER			Т	ULSA, OK 74136		j
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X8) DOMPLETION DATE
F 282	Continued From page	∌ 62		F 282			
	pressure ulcers on the low back, hip, and heel.				1	1	
	Apain assessment w	as completed on 10/08/13	. 1				
	The assessment reve	ealed the resident's			1		
)		scierosis and conditions of).	1	
		esure ulcers that would like ocumented the resident	ן עי		1		
		as needed pain medication	ı.				
	It was also document						
1		a duil, burning, fingling, plns in involved both upper and			1		
	lower extremities, oc						
		insity was rated seven on a	ι 1				
	pain scale of one to t				1		
	made the pain worse	positioning and movement					
		data collection, dated					1
		ed the resident experienced					1
1		n in both lower extremities, on a pain scale of one to					
	ten.	on a pair ocare or one to					
	Manihburghundalan				}		
1		ders, dated 10/2013, dent was to receive Aleve					
		r pain. There was no					1
{		y other pain medications	1				
	being ordered.		(1
	Monthly physician or	riers dated 11/2013					
1		dent was to receive Aleve					
{	200 mg one tablet er	very day for pain and Norce					1
		ets every four hours as					
1	needed for pain.						1
	A Peg Tube facility f	orm, dated 11/2013			1		}
		dent received Norco 7.5/32	25		1		
1		four hours as needed for	1		1		
L	pain.				1		1
FORM CMS-25	67(02-99) Previous Versions Of	osolele Even	t ID, NU5U11	F	acility ID; NH7226 If con	itinuation sheet	t Page 63 of 181

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		D HUMAN SERVICES					: 01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE I COMPL	
		375034	B. WING	_		C 12/17/2013	
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
	OOD CARE CENTER			1	3202 EAST 618T STREET		}
MAPLEN	JOD CARE GENTER			ין	TULSA, OK 74138		
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION)	id PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X8) Completion Date
F 282	Continued From page	9 63	F	282	2		
	The resident's care n	lan, updated 11/25/13,	1				
		lem/NeedShe will be	1		1		
		and all pain, using pain scale			4		
		ate with ordered medication	1				
1		lief obtainedGoalReceive dshe will be comfortable					
1	and achieve her goal						
		lief is not obtained consult					
	physician to change ordered"	or add to medication					
	Monthly physician or	ders. dated 12/2013.					
1		dent was to receive Aleve	1				
		r pain and Norco 7.5/325 mg					
	two tablets every fou	r hours as needed for pain.					
1		aton records, dated 12/2013,					
		co 7.5-325 Tablet 2 Tabs Per					
1	a slash mark through	rs As Needed" There was					
1		ions of the Norco, and the					
1	numeral "1" was writ	Contraction of the second					}
1	Review of narcotic c	ount sheets, dated 12/01/13					
1	through 12/09/13, re	vealed documentation the					
1		on a daily basis, a Norco	l				
{	a.m., 12:00 p.m., and	each tube feeding, at 9:00			{		
		a tion pille					
		a.m., LPN #3 was observed					
1	administering pressu	ire ulcer care to resident #3.	1				
		served to be severely					
		s and knees. The resident's			1		
		the left from the walst down					
		and crossed at the ankles ct in areas creating high risk					
	pressure points.	and the state of the state					

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Event ID: NU5U11

Facility ID: NH7226

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DEPART		D HUMAN SERVICES					: 01/09/2014	
		MEDICAID SERVICES					APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE		
		375034	B. WING	_		C 12/17/2013		
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEW	DOD CARE CENTER		6202 EAST 61ST STREET					
					TULSA, OK 74138			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies Y Must be preceded by full SC identifying information)	(D PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY)	BE	(25) Completion Date	
F 282	Continued From page	∍ 64	F	28	32			
	The LPN stated the n administered pain me the wound care begin	edication 30 minutes prior to						
	The resident was ask scale of one to ten. S	ted to rate her pain on a She stated, "Eight."						
	spasms. When the L	able to relax due to muscle PN would touch the begin having muscle spasms,						
		on of the resident's lower ent would yell out, "Oh, Oh."						
	red, and her eyes we	y flushed, her cheecks were are wide. She had a grimace arful look when she knew						
		sident was asked if she had ation prior wound care. She						
	effective. She stated	e felt the pain medication was 5, "They tell me I take the cation they can give me, but I er one."						
		e ever refused repositioning. nes. It hurts. They can't get						
	resident's pain medi administering wound	#2 was asked if she feit the cation was effective when i care. She stated, "She has n you touch or move her."						
	At 10:55 a.m., CNA	#2 was asked how she knew						

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Event ID: NUSU11

Feolity ID: NE17226

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EDICAID SERVICES					APPROVED .0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
375034	B. WING			1	C
		Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
		(6202 EAST 61ST STREET		1
			TULSA, OK 74136		1
Ment of Deficiencies (USY be preceded by Full.) Identifying Information)			(EACH CORRECTIVE ACTION SHOULD	BE	(XX) COMPLETION DATE
5 when administering care.	F	28	82		
e did when she saw the he stated she would tell reposition the resident. ion aide will give her a she lets us move her but the stated, "She hates auses the resident pain, and moving her." e had told about the ated, "Everyone knows." harge nurses were aware. eared the resident's pain re in relieving the ated, "No, nothing m., LPN #2 was asked who oldent #3's pain ted, "Dr. [name withheid] was done with the uring pain assessments, ad medicate according to aused resident #3 to have a has MS and is super					
	IDENTIFICATION NUMBER: 375034 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 5 when administering care. a did when she saw the ne stated she would tell eposition the resident. on aide will give her a he lets us move her but he stated, "She hates uses the resident pain. Ind moving her." a had told about the sted, "Everyone knows." harge nurses were aware. eared the resident's pain e in relieving the ated, "No, nothing n., LPN #2 was asked who Ident #3's pain ed, "Dr. [name withheid] as done with the tring pain assessments. d medicate according to sused resident #3 to have	IDENTIFICATION NUMBER: A. BUILD 375034 B. WING MENT OF DEFICIENCIES ID UST BE PRECEDED BY FULL PREFIDENTIFY IDENTIFYING INFORMATION PREF 5 F when administering care. F e did when she saw the F he stated she would tell eposition the resident. on aide will give her a F he lets us move her but F he stated, "She hates Uses the resident pain. Ind moving her." F a had told about the F sted, "Everyone knows." F arage nurses were aware. F eared the resident's pain e in relieving the ated, "No, nothing n., LPN #2 was asked who ident #3's pain ed, "Dr. [name withheld] as done with the ring pain assessments. d medicate according to sused resident #3 to have has MS and is super Super	IDENTIFICATION NUMBER: A. BUILDIN 375034 B. WING	DENTIFICATION NUMBER: A BUILDING 376034 B. WNG STREET ADDRESS, CITY, STATE, ZIP CODE 8202 EAST 61ST STREET TULSA, OK 74135 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDE THE PRECEDED THE PRECED THE PRECED TO THE APPROPRIATION DEFICIENCY IDE THE PRECEDED STATES IDE THE PRECED THE PRECED TO THE APPROPRIATION DEFICIENCY IDE THE PRECED THE PRECED TO THE APPROPRIATION DEFICIENCY IDE THE PRECED THE PRECED TO THE APPROPRIATION DEFICIENCY IDE THE PRECED THE	IDENTIFICATION NUMBER: A BUILDING COMP \$75034 B. WNI3 12/ \$75034 B. WNI3 12/ \$75034 B. WNI3 12/ \$12/ \$76034 B. WNI3 12/ \$12/ \$76034 B. WNI3 12/ \$12/ \$12/ \$12/ 12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$12/ \$13/ \$13/ \$13/ \$13/ \$13/ \$13/ \$13/ \$13/ \$15/ \$12/ \$12/ \$12/ \$12/ \$15 \$12/ \$12/ \$12/ \$12/ \$15 \$12/ \$12/ \$12/ \$12/ \$15 \$12/ \$12/ \$12/ \$12/ \$15 \$12/ \$12/ \$12/

FORM CMS-2567(02-99) Previous Versione Obsolete

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Event 10: NU5U11

Facility ID: NH7226

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		MEDICAID SERVICES					0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		DNSTRUCTION	(X3) DATE COMP	SURVEY
		375034	B. WING			C 12/17/2013	
AME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				EAST 61ST STREET SA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) Completion Date
F 282	Continued From page	a 66	F	282			
		activities known to cause	1 .	202			
		tried to make sure the	1				ļ
		medication, and she					
		worked. She stated the	}				
		ain medication be given					
	before each tube fee	ding.	1				{
	She was asked what	the resident's nain					1
		the stated, "Norco and Aleve,					
	Baclofen, Neurontin.						1
		n the last time the resident's	ļ				1
		been adjusted. She stated,					
		ng as I been taking care of same." She stated she had	1				
	been at the facility le		{				
	She was asked why were chosen. She s	those specific medications tated, *I don't know."					
	She was asked why	the resident had been told					1
		strongest pain medication					
	she could be on. Sh	e stated, "I don't know who	1	1			
	told her that."			1			
	On 12/12/13 at 11.0	0 a.m., the medication					
		d was reviewed. It was					1
		ident had received Baclofen		1			1
	20 mg, Aleve 220 m	g, and one tablet of Norco					
	7.5/325 mg at 9:00 a	a.m.	1				
	On 12/13/13 at appr	oximately 9:50 a.m., Dr.		ł			
		asked if staff had informed	}	1			
		t had increased pain with					{
		sing treatment. He stated,	1	{			
		out that." The physician		1			1
		s pain would never be		1			
		due to her diagnoses. He					
	stated mar sometime	es, just breathing on the		1			1

FORM CM6-2567(02-99) Previous Versions Obsolele

Event ID; NU5U11

Facility ID: NH7226

If continuation sheet Page 67 of 181

		D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375034	B. WING	_		C 12/17/2013	
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	DOD CARE CENTER				8202 EAST 81ST STREET		
				-	TULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	XF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSE-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(XS) COMPLETION DATE
F 282	resident could cause stated because of the pain was extremely d He was informed that medication was Aleve nothing." He was asked what h known the resident w her pressure ulcer tre would have increased He was asked if he d him of resident's pair He stated, "Yes I do, ears. I depend on th The physician was a someone had decree Norco 7.5/325 mg fro hours to one tablet, w tablet did not control don't."	her excructating pain. He e resident's diagnoses, her lifficult to manage. It the resident's routine pain a. He stated, "That's ne would have done if he had was having increaed pain with eatments. He stated, " I d her pain medication." Repended on staff to inform hevels and issues with pain. they are my eyes and my em." sked if he knew why aed the resident's as needed on two tablets every four when it was known that one her pain. He stated, "No, 1 a.m., the DON was asked of or the pain management am." She was asked how rogram. She stated the am audited and looked at the	F	28			
	The DON was asked pain was controlled of level possible. She ask the resident abo medication and if it y expected the nurses	I how she ensured residents' effectively and to the best stated she expected staff to ut their pain after taking pain vas not controlled, she to follow up. She stated e made with the nurses and					

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Event ID: NU5U11

Facility ID: NH7226

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		ID HUMAN SERVICES				FORM	01/09/2014 APPROVED 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE S COMPL	ETED	
		375034	B. WING			C 12/17/2013		
NAME OF P	ROVIDER OR SUPPLIER			(STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEW	DOD CARE CENTER			(202 EAST 61ST STREET FULSA, OK 74136			
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRET TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(25) COMPLETION DATE	
F.282	Continued From page she reviewed the twe	e 68 nty-four hour reports,	F	282				
	the pain program was as a system or for a s all aspects of care wo	what she did if she identified a not being effective either specific resident. She stated suld be reviewed and a ind., She stated she would						
		admitted to the facility on ses that included a stage III plostomy.						
	total assist with bathl dressing" The goa with all her ADL funct needs/wants met on review" Approache catheter and coloston as needed when not	m, "requires extensive to ng, bed mobility, tolleting, I was, "will have assistance tions to have her a daily basis thru next as included, "Empty foley my pouch with each shift and ad that is is fullPlace call th when in room, answer						
	in placeis bedfast a goal was, "will not complication/obstruc included, "Empty c pm, do not let colost	tion" Approaches olostomy pouch q shift and						
	condition[s]" One exacerbation of COF identify [sic] thru nur Approaches included	D, CHF, A-Fibb [sic] will be						

FORM CM8-2587(02-99) Previous Versions Obsciete

Event ID: NU6U!1

Facility ID: NH7226

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	01/09/2014 APPROVED 0938-0391	
	FDEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(X2) MUL		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		375034	B. WING			12/1	7/2013	
NAME OF PR	OVIDER OR SUPPLIER		L	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>		
				6	202 EAST 61ST STREET		}	
MAPLEWO	OD CARE CENTER			1	TULSA, DK 74136		}	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X8) COMFLETION DATE	
F 282	11/25/13 documented intact, required exten mobility and toilet use personal hygiene. It resident had a colost On 12/11/13 at 5:03 a feces was noted from from the resident's ro The resident's light w entered the resident's "Ma'am, can you help to be changed out, at surveyor asked the n her call button for as asked, "Where is it?" to be between the re upper side rall. It was The call light was giv pushed the button. The have dried feces cov resident's gown and feces. The resident's feces was noted to c At 5:08 a.m., CNA #' room. The resident is turned on the light. It the juncture of the re urinary catheter tubin colostomy bag was e	sion assessment, dated it the resident was cognitively sive assistance with bed a and limited assistance with was documented the omy and urinary catheter. a.m., a very strong smell of a the hallway to be coming om. The resident asked, o me? My colostomy needs nd I can't do it." The asident if she had pushed sistance. The resident "The call light was observed sident's mattress and the left s out of the resident's reach. en to the resident, and she fhe resident was noted to ering her left hand. The bed linens were covered with a abdomen was exposed and	F	282				
FORM CMS-25	Skin and the seal of t				Fecility ID: NH7226 If contin		Page 70 of 181	

			FORM	01/09/2014 APPROVED
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	SURVEY
375034	B. WING_		520	7/2013
		STREET ADDRESS CITY STATE ZIP CODE		112013
	- 4]
		TULSA, OK 74136		
Y MUST BE PRECEDED BY FULL	id Prefi Tag	X (EACH CORRECTIVE ACTION SH	HOULD BE	(X8) COMPLETION DATE
resident's soiled gown and undied them up, and without off the room, went down the ad them in the soiled linen id at room #30 on the center MA #7's help. The resident's colostomy had asked CNA #1 if the bag CNA #1 stated, "It's full. It's 1 was asked how offen she ent. She stated, "Every two red when the resident was tated, "I don't know the exact and 3:30 [a.m.]." CNA #1 ocked the resident's a stated, "No, I didn't." She e in I check the bags [urinary olostomy." CNA #1 was the dher shift. She stated a asked when she emptied the ed at the beginning and end 1 was observed to be ew colostomy bag on the athered the soiled linens from 1 them in a bag, and without left the room. She went , placed the bag of soiled ; and went into room #52 and if she had put the new is resident. She stated, "Yes." is had put the new is resident. She stated, "Yes." is had been trained to replace the stated, "No. That was my A#1 was asked if there was	F			
		Facility ID: NH7226	f continuation chant	Page 71 of 194
	ATEMENT OF DEFICIENCIES Y MUST BE PRECEIVED BY FULL LSC IDENTIFYING INFORMATION)	MEDICAID SERVICES (X1) PROVIDERSUPPLIENCUA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 375034 B. WING A. BUILDI 375034 A. BUILDI 375034 ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PREFI TAG a 70 Fill b resident's solled gown and undled them up, and without eff the room, went down the ad them in the solied linen id at room #30 on the center MA #7's help. * the resident's colostomy had asked CNA #1 if the bag DNA #1 stated, "it's full. It's 1 was asked how often she lent. She stated, "Every two ked when the resident was tated, "I don't know the exact and 3:30 [a.m.]." CNA #1 solostomy." CNA #1 woolostomy." CNA #1 was ted her shift. She stated a stated when she emptied the ted at the beginning and end 1 was observed to be ew colostomy bag on the athered the solied linens from them in a bag, and without left the room. She went t, placed the bag of solied r, and went into room #62 and If she had put the new he resident. She stated, "Yes." he had been trained to replace the stated, "No. That was my A#1 was asked if there was	MEDICAID SERVICES (x1) PROVIDERSUPPLEMERTIA IDEMTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 376034 B. WING 376034 B. WING STREET ADDRESS, OTY, STATE, ZIP CODE 6202 EAST 615T STREET TULSA, OK 74185 ATEMENT OF DEFICIENCIES D PROMETRY AN OF CODE ATEMENT OF DEFICIENCIES D PREFIX PROPERTY AN OF CODE CODECTIVE ATTOR (CAD ACT AT STREET TULSA, OK 74185 D PREFIX D PREFIX D PREFIX D PREFIX D PREFIX CODECTIVE ATTOR (CAD ACT AT ATTOR DEFICIENCY) A TO F 282 PREFIX D PREFIX B TO F 282 'In resident's solied gown and undied them up, and without at the room #30 on the center MA #7's help. 'In the solied linen da troom #30 on the center MA #7's help. 'In the solied linen solied linen datad, "I don't know the exact and 3:30 (a.m.]" CNA #1 vasted when she emptice the a stated, "No. I didn't." She e in I check the bags (untary obostomy." CNA #1 was the colled linens from them in a bag, and without is the resident solied linens from them in a bag, and without the the room. She went i, placed the bag of solied ; and went into com #52 and If she had put the new the resident. She stated, "Yes." the had been trained to replace the stated, "No. That was my shift to meet the residents' <td>DI HUMAN SERVICES ONE DO MEDICAD SERVICES ONE NO. (1) PROVIDERSUPPLERCIA (2) MULTIPLE CONSTRUCTION (2) ONE 10 ENTRICATION NUMBER: 0.00 MULTIPLE CONSTRUCTION (2) ONE 378034 B. WIN9</td>	DI HUMAN SERVICES ONE DO MEDICAD SERVICES ONE NO. (1) PROVIDERSUPPLERCIA (2) MULTIPLE CONSTRUCTION (2) ONE 10 ENTRICATION NUMBER: 0.00 MULTIPLE CONSTRUCTION (2) ONE 378034 B. WIN9

Fedlity ID: NH7226

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	,	375034	B. WING			12/1	7/2013
NAME OF PE	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1.	202 EAST 61ST STREET		}
MAPLEWO	DOD CARE CENTER			1	TULSA, OK 74136		}
px4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	, 1	005
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAC	5	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	PAIE
F 000	0		1 _			1	
F 282	Continued From page		F	282	: ()	1	ſ
		Usually. That's the worst)	}
		I. I was trying to get people	}			ł	
		d all my time. The resident	1				
	had to wait."		{				1
	On 12/12/13 at anom	ximately 8:30 a.m., the				1	
		d she had reviewed the	1			}	
		the aide had been in the				1	1
1		n times during her shift. The				1	1
	corporate nurse prov	ided documentation of the	1			1	
	times the CNA had e	ntered the room. The time					
{		room on each visit ranged	1				
	the second second second second second	es. It was documented					
		r, either an RN or CMA,					
		4:44 a.m. and spent 12					
	minutes in the room.		1				
	The surveyor evolain	ed the aide had stated she			{		
		resident's colostomy bag	1		1		
}		of the shift. The corporate	1		1		
ł		dent had ate beans and					
{	cabbage for the prev	ious evening meal, causing			4		
{	Increased gas. She	stated some nursing homes					
		ostomy bags but once per	}				
	shift.		1				
{	0- 4047440 -6040	DOM					
{	and the second	a.m., the DON was asked as received regarding	{				
		e stated, "I need to look into					
		d to empty every shift."	1				
ł	anay moy alo salle	a to output overy outre	1				
1	She was asked how	the staff would know if the	1				
		using foods. She stated the	1		}		
}		ted on the board by the					
1		was asked what staff was					
		y knew a resident had	1				
		ucing food. She stated they)				
1	should check the col	ostorny more often.					
L							
FORM CMS-25	67(02-89) Previous Versions Ob	event ID: NUE	1011	F	acility ID: NH7226 If contin	uation sheet	Page 72 of 181

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		CONSTRUCTION	(X3) DATE	
		375034	B. WING			12/	; 17/2013
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				620	2 EAST 61ST STREET		
MAPLEWO	OOD CARE CENTER			ти	LSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	1D PREF1 TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
F 282			F	282			
	changing the bag. SI	who was responsible for he stated, "The nurse heips turse has instructed the CNA					
	11/15/13 with diagnos	admitted to the facility on ses that included diabetes myelitis, chronic pain, and sls.					
		ction form, dated 11/15/13, Intact no skin breakdown ncisions intact*					
	A body audit form, da no skin problems.	ated 11/17/13, documented					
	breakdowndecreas generalize[d] muscle	vian, dated 11/19/13, olem: Potential for skin se in mobility secondary to weakness, he requires ing and incontinent careHe					
	noted [sic] fragile ski DiabetesApproach Document all new ski PCPReposition [re						
	An initial assessment	t, dated 11/22/13, dent was cognitively intact,					
	needed extensive as	sistance with ADLs, had an theter, was incontinent of					
	A Braden scale for p dated 11/22/13, doc	redicting pressure sore risk, umented the resident scored the resident was at risk to					
EORM CMS-25	67(02-89) Previous Versions Ol			Fac	lilly ID: NH7226 If cont	nustico sheet	Page 73 of 181

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STATEMENT OF DERIGENCIES AND PLANDER OF CORRECTION ADDITION NUMBER (X) PROVIDERSUPPLIES DEFINITION NUMBER 375834 (X) PROVIDERSUPPLIES B. WING (X) PROVIDERSUPLIES B. WING (X) PROVIDERSUPPLIES B. W			D HUMAN SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391	
376034 B_WHG 12/17/2013 NWAE OF PROVIDER OR SUPPLIER STREET ACRESS, CRTV, STATE, ZP COCE MAPLEWOOD CARE CENTER STREET ACRESS, CRTV, STATE, ZP COCE MAPLEWOOD CARE CENTER STREET ACRESS, CRTV, STATE, ZP COCE OPEND STREET STREET TULSA, OK 74135 OPEND STREET STREET DEPRETACT CONSTRET FLAGRESS, CRTV, STATE, ZP COCE OPEND STREET STREET TULSA, OK 74135 PROVIDER OF MADE TER PROVIDER TO THE APPROVENCE Open colspan="2">Open colspan="2">Open colspan="2">Open colspan="2">Open colspan="2">Open colspan="2">Open colspan="2">Open colspan="2" TAC PROVIDER OF OF DEFICIENCES PROVIDER OF OF DEFICIENCES Open colspan="2" TAC PROVIDER OF NUME TERPECTOR OF TALL PREX PROVIDER OF NUME TERPECTOR OF TALL TAC PROVIDER OF NUME TERPECTOR OF TALL TAC PROVIDER OF NUME TERPECTOR OF TERE OF NUME Continued From page 73 F 282 A daig stifted nurber of table 12/08/13 at <th colspan<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>COMPL</td><td>eted</td></th>	<td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>COMPL</td> <td>eted</td>							COMPL	eted
MAPLEWOOD CARE CENTER 5202 EAST 51ST STREET TULSA, OK 74135 Ore ID PRETX TVG SLIMMAY STATEMENT OF DEFICIENCIES (PROVIDER IN A OF CORRECTION PRETX TVG PROVIDER IN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HEAPPROTECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HEAPPROTECTION DEFICIENCY) DOWNTTON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROLLING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROLLING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROLLING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROLLING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED CONTROLLING (EACH CORRECTIVE ACTION SHOULD BE CROSS-RE			375034	B. WING			1		
MAPLEWOOD CARE CENTER TULSA, OK 74136 04010 SUMMARY STRUMMENT OF DEFICIENCIES REACH EXERCISENT MUST BERECEDED BY FULL PRECEDENT BY MUST	NAME OF PI	ROVIDER OR SUPPLIER							
Precipy TAG REACH DEFICIENCY MUST BE FRECIDED BY FLIL RESULATORY OR USD. DENTIFYING INFORMATION) PREFIX TAG CACH DEFICIENCY AND SHOULD BE CROBE-REFERENCED to HE APPROVED TO THE APPROVED TO UNIT F 282 Continued From page 73 A body audit, dated 11/24/13, documented the resident idd not have a skin problem. F 282 A daily skilled nurses' nots, dated 11/24/13 at 7:00 pm, documented, "Resident noted to have reciness to buttocks. N/O to apply calmoseptine to buttocks q shift urtil resolved" F 282 A body audit from, dated 12/05/13, documented, "secrum red, excortated" F A body audit form, dated 12/08/13, documented, "secrum red, excortated 12/08/13, documented, "calmoseptine to buttocks q shift & pm. Dx: open areas" , An update to the care plan, dated 12/08/13, documented, "calmoseptine to buttocks Q shift & pm. Dx open areas" A daily skilled nurses notes, dated 12/08/13 at 9:30 pm., documented, "Wound nurse noted superficial open areas" A daily skilled nurses notes, dated 12/08/13 at 9:20/13 at 12/09/13 at 2:16 p.m., a resident interview 0	MAPLEW	OOD CARE CENTER							
A body audit, dated 11/24/13, documented the resident did not have a skin problem. A daily skilled nurses' note, dated 11/24/13 at 7:00 p.m., documented, "Resident noted to have redness to buttocks. N/O to apply calmoseptine to buttocks q shift until resolved" A body audit form, dated 12/05/13, documented, "secnum red, exconiated" A body audit form, dated 12/08/13, documented, "2 amail open superficiel areas to secrum" A physiclan's order, dated 12/08/13, documented, "calmoseptine to buttocks q shift & pm. Dx: open areas" An update to the care plan, dated 12/08/13, documented, "Calmoseptine to buttocks Q shift & pm. Dx open area" A daily skilled nursee notes, dated 12/08/13 at 9:30 p.m., documented, "Wound nurse noted superficial open areas to buttocks. N/O calmoseptine Q shift pm. Bedpen provided as order" Medication administration records, dated 12/08/13 at 12/09/13, documented the calmoseptine was applied three times each day. On 12/10/13 at 2:16 p.m., a resident Inferview	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	٦X.	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION	
not answer his call light. He also stated staff would put him on the bed pan and not come back. He was asked how long staff left him on the bed	F 282	A body audit, dated 1 resident did not have A dally skilled nurses 7:00 p.m., documente reciness to buttocks. to buttocks q shift und A body audit form, da "sacrum red, excort A body audit form, da "2 small open supe A physiclan's order, o "calmoseptine to bu open areas" An update to the carr documented, "Caln & pm. Dx open area 9:30 p.m., document superfidal open area calmoseptine Q shift order" Medication administr 12/08/13 and 12/09/ calmoseptine was ap On 12/10/13 at 2:16 was conducted. The not answer his call li would put him on the back.	1/24/13, documented the a skin problem. I note, dated 11/24/13 at ad, "Resident noted to have N/O to apply calmoseptine bill resolved" Atted 12/05/13, documented, inted 12/08/13, documented, rficial areas to sacrum" Atted 12/08/13, documented, rficial areas to sacrum" Atted 12/08/13, documented, uttocks q shift & pm. Dx: a plan, dated 12/08/13, noseptine to buttocks Q shift " a notes, dated 12/08/13 at ed, "Wound nurse noted is to buttocks. N/O pm. Bedpan provided as atton records, dated 13, documented the oplied three times each day. p.m., a resident interview a resident stated the staff did ght. He also stated staff a bed pan and not come	F	282				

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Event ID: NU5U11

Facility ID: NH7226

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CENTER		ID HUMAN SERVICES	5				PRINTED: FORM OMB NO.	APPROV 0938-03
	CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUME	in the second se		E CONSTRUCTION		COMPLI	ETED
		375034	B. With	VG			-	7/2013
NAME OF PE	OVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				202 EAST 61ST 8TREET TULSA, OK 74136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL PR	id Lefix Tag	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLET DATE
F 282	pan. He stated, "One timed it once, and it was intrues." He was as light on. He stated, " time." On 12/11/13 at 8:03 a if he had any problem "Yes." He rolled over onto h Il pressure ulcers, ap each, were observed left buttock. The ulce pattern, similar to the stated, "They are sta At 8:55 a.m., the resi had been left on the hour this week." He Tuesday, or Sunday, on the bed pan for "e hours or more. He was asked when pan for two hours or this room, two weeks [CNA #16]. She told she wasn't because in the hall." On 12/11/13 at 9:02 the resident had a tri pressure ulcers. Shi	a time It was two hours vas one hour and fifty ked if he had turned h Yes, it was on the who a.m., the resident was ns with his skin. He st is right side and three proximately 1cm x 0.5 on his upper buttocks ars were in an arched o outline of a bed pan.	is call ble asked ated, stage form a and He he "An onday, en left wo e bed vas in l t was l knew beople ated if li a facility	F 282				
		e of cream out of the Is labeled "skin repair						

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014
		MEDICAID SERVICES					APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375034	B. WING				C 17/2013
NAME OF P	ROVIDER OR SUPPLIER	h		T	STREET AODRESS, CITY, STATE, ZIP CODE		
	DOD CARE CENTER				6202 EAST 61ST STREET		
	JOD CARE CENTER				TULSA, OK 74136		
(X4) 1D PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be preceded by full LSC identifying information)	ID PREF TAG	XF	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 282	Continued From page	ə 75	F	282	2		
	the nurses had to put	used this cream. She stated it on. She stated it was mented on the resident's					
	On 12/11/13 at 9:17 a.m., the resident was asked If staff had applied a cream to his bottom. He stated, "They use some kind of salve." He was asked who applied the salve, CNAs or LPNs. He stated, "Both." He was asked when they had applied the cream. He stated when he had a bowel movement. He was asked how many times a day the cream had been applied. He stated, "I only have a bowel movement one time a day."						
	what she did to help	5 a.m., CNA #6 was asked prevent pressure ulcers. em and keep them dry."					
		n she placed someone on a id to make sure she did not ated, "I just know."					
	breakdown. She sta	ident #12 had any skin ted, "Yes." She was asked akdown. She stated about					
	what he did to help p stated, "I turn reside	5 a.m., CNA #10 was asked prevent pressure ulcers. He nts at least every two hours t of bed if the resident is able.					
		he did when he placed ean to make sure he did not		_			

FORM CMS-2567(02-98) Provious Versions Obsolate

Event ID: NU5U11

Fecility ID: NH7226

If continuation sheet Page 76 of 181

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					: 01/09/2014	
		MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		375034	B. WING					
NAME OF D	ROMDER OR SUPPLIER	3/8034		-	STREET ADDRESS, CITY, STATE, ZIP CODE	120	7/2013	
	WIJCH ON SUFFLIER			1	6202 EAST BIST STREET			
MAPLEWO	OOD CARE GENTER			1	TULSA, OK 74136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X8) COMPLETION DATE	
F 282	Continued From page forget about them. H stepped out the door He was asked if resid breakdown. He state he had just started w was on two days prev On 12/11/13 at 11:10 resident #12 had any stated he had "redne asked if he had any of couple of areas were She was asked how ensure they were iny ald in prevention of a she stated, "i usually the CNAs." She was asked how providing quality care and ask them if there On 12/17/13 at 9:00 who was responsible to aid in the preventi- ulcers. She stated, "i was obtained from th therapy, and the wee She was asked how interventions were id	a 76 ie stated he usually just until they are finished. ient #12 had any skin id he did not know because orking the hail the resident viously. a.m., LPN #9 was asked if skin breakdown. She ss" to his bottom. She was open areas. She stated, "A open today." she monitored the CNAs to blementing interventions to kin breakdown. have to do it myself or I ask she ensured CNAs were b. She stated, "I make rounds		7 282				
FORM CMS-95	On 12/17/13 at 9:53 how she ensured res	a.m., the DON was asked sidents were not left on bed veriods of time. She stated	105011		Facility ID: NH7228 · }f cont	nuetion sheet	Page 77 of 181	

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/09/2014 APPROVED . 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE S COMPL	BURVEY ETED
		375034	B. WING			C 12/1	7/2013
NAME OF P	ROVIDER OR SUPPLIER			81	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				102 EAST 61ST STREET		
NAID	SI MANY ST	ATEMENT OF DEFICIENCIES	In		PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	id Prefi Tag		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 282	the aldes were support that she was unaware She stated she review times on the compute She was asked if she breakdown on his coor was aware of two red The DON was asked to the opened areas. to apply the medicatil asked if she was aware resident was receiving but the resident state once a day. She state amount of medication discharged from the the applied more than on The DON was asked performed. She state team on the weekend	e of any problems with this. wed the call light response or. was aware the resident had coyx area. She stated she and opened areas. who applied the medication She stated the nurses were on on each shift. She was are it was documented the g the oream on each shift d it was only being applied ted no. She stated the in left when the resident facility showed it was being	F	282			
F 283 SS=E		TICIPATE DISCHARGE: . STATUS	F	283	F283 1. Resident #25 no longer resi	ides in	.1
	When the facility anti- must have a discharg recapitulation of the summary of the resid- in paragraph (b)(2) of the discharge that is authorized persons a	icipates discharge a resident ge summary that includes a resident's stay; and a final dent's status to include items if this section, at the time of available for release to and agencies, with the ant or legal representative.			this facility. 2. All residents discharged ha potential to be affected. Dis summaries will be review ensure accuracy and complete 3, Nursing supervisors will be serviced by the DON/Design	the the scharge red to eness to in	'DITH

FORM CMS-2567(C2-69) Previous Versions Obsoleta

Event ID: NU5U11

Facility ID: NH7228

If continuation sheet Page 78 of 181

		D HUMAN SERVICES					01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		-		OMB NO.	0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/GLIA IDENT/FIGATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		376034	B. WING			C 12/1	7/2013
NAME OF PR	ROVIDER OR SUPPLIER			ទ	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADIEW	OOD CARE CENTER			6	202 EAST 61ST STREET		(
	JOD GARE CENTER			Т	ULSA, OK 74136		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 283	by: Based on interview a determined the facility discharge summary fi sampled residents wi reviewed. This had ti that resided in the fac A facility policy on dis planning, dated 12/20 discharge summary the resident's stay at summary of the resid the discharge in accor regulations The discharge summ description of the resid the discharge summ description of the resid the facility and entering the facility a diagnoses Physical and mental Sensory and physica Nutritional status and Cognitive status Drug therapy A copy of the post-di will be provided to th facility and a copy wi medical records" Resident #25 was a 11/11/13 with diagno	Is not met as evidenced und record review, it was y failed to complete a for one (#25) of three hose closed records were the potential to affect 163 clifty. Findings: scharge summaries and 112, documented, "The will include a recapitulation of this facility and a final ent's status at the time of indance with established ary shall include a ident's: and prior medical history nd current medical functional status il impairments ischarge plan and summary a resident and receiving Il be filed in the resident's dmitted to the facility on	F	283	4. Audits will be completed to ensure discharge summarie complete and accurate weekl monthly x 4 and as needed. I will be reviewed in the (Assurance meeting.	es are y x 4, Results	
	disease stage IV.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NU5U11

Facility ID: NH7226

If continuation sheet Page 79 of 181

ATEMENTO	FDEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE S	
id plan of	CORRECTION	IDENTIFICATION NUMBER;	A. BUILDI	NG		COMPL	
		375034	B. WING			C 12/1	7/2013
AME OF PF	NOVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				02 EAST 61ST STREET ULSA, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag				
F 283	12/03/13, documente	e 79 charge summary, dated d, "Admission date: date: 12/3/13Treatment	F	283			
	provided: general nu therapy" The discharge summ synopsis of the reside	rsing care ¢ PT, OT					
	DON, and corporate resident's discharge	ere is the synopsis of the					
	They were asked if the were dispensed to his response was given.	ated, "It's too general." he resident's medications m upon discharge. No hat happened to the resident's			:		
F 309 SS=H	personal belongings. 483.25 PROVIDE C/ HIGHEST WELL BE	No response was given. ARE/SERVICES FOR ING	. [.] F	309	1a. On 12/14/13, resident #3's physician was notified of her	-	њµи
	provide the necessa or maintain the higher mental, and psychos	receive and the facility must ry care and services to attain est practicable physical, loctal well-being, in comprehensive assessment			The physician ordered her to on dilaudid 1mg per peg q 4 routinely at this time. 1b. Resident #16 was interv and feels that her pain medicat effective on 12/17/13. Sh educated to report pain that	hours viewed ion are e was	

FORM CM9-2587(02-99) Previoue Versions Obsoriete

Event ID: NU6U11

Feolity ID: NH7226

If continuation sheet Page 80 of 181

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	S FOR MEDICARE &					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPI.IER/CLIA IDENTIFICATION NUMBER:	A BUILDING	CONSTRUCTION	(X3) DATE		
			A BOLDING				
		375034	B. WING		12/17/2013		
NAME OF P	ROVIDER OR SUPPLIER		1 8	TREET ADDRESS, CITY, STATE, ZIP CODE			
			8	202 EAST 61ST STREET			
MAPLEW	DOD CARE CENTER		Т	ULSA, OK 74136			
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	id Prefix Tag	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 309	 by: Based on observation review, it was determ A. Recognize pain, of pain management interventions for two sampled residents with the effectiveness of plinterventions for two sampled residents with the facility's failure to actual harm for resident facility's Census and 110 residents as being program. The facility's census and 110 residents as being program. The facility's receiving routine and medications; B. Provide bladder medications; B. Provide bladder medications; C. Ensure an edema by the physician for or center of the physician for the physici	is not met as evidenced In, interview, and record Ined (the facility failed to: levelop and/or implement erventions, and/or monitor lain management) (#3 and #16) of thirteen no were reviewed for pain. o manage pain resulted in ents #3 and #16. The Conditions report identified ig on a pain management I dentified 72 residents as /or as needed pain etraining as ordered by the 2) of one sampled resident er and physician's orders for he facility identified 18 a urinary catheter; and a glove was worn as ordered one (#5) of one sampled a potential to affect 163	F 309	 1c. Resident #12 no longer rest this facility 1d. Resident #5 order was or to apply in am and remove in 12/12/13. 2a & b. All residents reprove a non-constraint of the potential affected. A pain screet completed on these reside 01/17.14. 2c. All residents with catheters have the potential affected. All residents with catheters have the potential affected. All residents with a for bladder retraining by 12/12. 2d. All residents with orthotit the potential to be affected review of residents with orthotit the potential to be affected review of residents with orthotit they were being applied physician order. 3. All nursing staff were inside by the DON on 1/20/14 repain, bladder retraining the potential constrained for the potential constrained to be affected they were being applied physician order. 	larified pm on ceiving pain al to be n was nts by urinary to be catheter he need 7/13. cs have d. A rthotics ensure d per erviced garding		
	documented, "Asse RecognitionInclude diagnoses or condition	n pain, dated 04/2013, essment and as a review of known ons that commonly cause or a to painReview for any		retraining is performed as	treated bladder		

FORM CM8-2587(02-89) Previous Versions Obsolete

Event ID: NU5U11

Facility ID: NH7228

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					: 01/09/2014 APPROVED
CENTER	SFOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0938-0391
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMPI	
		376034	B. WING			12/1	; 17/2013
NAME OF PE	ROVIDER OR SUPPLIER			ទា	TREET ADDRESS, CITY, STATE, ZIP CODE		
				62	202 EAST 61ST STREET		1
MAPLEW	DOD CARE CENTER			τ	UL8A, OK 74136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(XS) COMPLETION DATE
F 309	Continued From page admission to the facil whenever there is a s condition and at any f staff will reassess the consequences of pair 1. Resident #3 was a 09/14/11 with diagnos sclerosis (MS), chron contractures, multiple and myalgle. The res medications via a per tube. Physicians orders, da the resident was to re two tablets every eig 10 mg every six hour Zanaflex 4 mg every acetaminophen 640 needed for pain. A physician's order, of documented to decree 7.5/325 mg every eig A physician's order, of the resident could re- every eight hours as	a 81 ity, at each quarterly review, ignificant change in time pain is suspectedThe individual's pain and in at regular intervals* admitted to the facility on ses that included multiple ic pain, dysarthria, joint a pressure uicers, diabetes, sident received all routaneous gastrostomy ated 02/2013, documented aceive Norco 7.5/325 mg, int hours for spasms, and mg every fours houre as bated 02/08/13 at 7:00 p.m., base the resident's Norco to pht hours for pain. dated 02/17/13, documented ceive Norco 7.5/325 mg needed for pain.		309	DEFICIENCY)	nd as	
	[Name withheld] [con	d 02/19/13, documented, " nplains of] pain[one] tab ve painRequested to have ."					
	to increase the pain i	dated 02/19/13, documented medication back to Norco sts every eight hours routinely					

FORM CMS-2567(02-95) Previous Versions Obsolete

Event ID: NU5U11

Facility ID: NH7226

If continuation sheet Page 82 of 181

		D HUMAN SERVICES				FORM	01/09/2014 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_			0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375034	B. WING			12/1	7/2013
NAME OF PR	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
	OD CARE CENTER			1	6202 EAST 61ST STREET		
MAPLEM	JOD CARE CENTER				TULSA, OK 74138		
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	ə 82	F	30	99		
	the resident was to re- two tablets every eight mg every eight hours every twelve hours as re-admitted to the fac The facility admission 06/11/13, documente Norco 7.5/325 mg tw for pain and acetamin hours as needed for The diagnosis descri- stage IV, multiple sol contracture, and com Another facility admis 06/11/13, documente Norco 5/325 mg eve pain and naproxen 2 needed for pain. A physician order, da increase the residen tablets every six hour A quarterly assessmedocumented the real	pitalized on 05/20/13 and slity on 06/11/13. In/start-up orders, dated of the resident was to receive to tablets every eight hours hphen 650 mg every four pain. Inform included Sacral ulcer erosis, dysarthria, left leg tracture of the hand. Information the hand. Information the same second for 50 mg every 12 hours as ated 06/14/13, documented to t's Norco 7.5/325 to two irs.					
	mobility, transfers, a documented the resi	ance from staff for bed nd all ADLs. It was ident's upper and lower lotion was impaired due to					
	It was documented t	he resident was on a			<u> </u>		

FORM CMS-2567(02-99) Previous Versions Obsolate

Event ID: NU5U11

Fedility ID: NH7226

If continuation sheet Page 83 of 181

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 375034 B. WING C 12/17/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST 61ST STREET MAPLEWOOD CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST 61ST STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE C (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE C F 309 Continued From page 83 F 309 F 309 F 309 F 309 IDEFICIENCY) IDEFICIENCY) IDEFICIENCY) IDEFICIENCY) IDEFICIENCY) F 309 Continued From page 83 F 309 </th <th>1/09/2014 PROVED 938-0391</th>	1/09/2014 PROVED 938-0391
375034 B. WING 12/17/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6202 EAST 61ST STREET MAPLEWOOD CARE CENTER TULSA, OK 74138 TULSA, OK 74138 (K4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAS PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) or F 309 Continued From page 83 scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. F 309 It was also documented the resident had three It was also documented the resident had three	IVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MAPLEWOOD CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAPLEWOOD CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAPLEWOOD CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 83 scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. It was also documented the resident had three	2013
MAPLEWOOD CARE CENTER TULSA, OK 74136 (X4) ID PREFIX TAS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC F 309 Continued From page 83 scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. F 309 It was also documented the resident had three It was also documented the resident had three	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C F 309 Continued From page 83 scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. F 309 F 309 It was also documented the resident had three It was also documented the resident had three It was also documented the resident had three	
scheduled pain medication regimen and had received as needed pain medication. It was also documented the resident's pain was frequent with an intensity of eight, on a pain scale of one to ten. It was also documented the resident had three	(X5) Ompletion Date
stage III pressure ulcers and one stage four pressure ulcer. There were three unstaged slough/eschar pressure ulcers. A physician order, dated 06/18/13, documented to increase the resident's Norco 7.5/325 mg to two tablets every four hours. An assessment of contracture risk was completed on 06/20/13. The total score was ten. This Indicated the resident's was completed on 06/20/13. The total score was ten. This Indicated the resident was at risk and required a regular positioning schedule for both bed and chair. Predisposing factors were documented as bilateral upper and lower extremity flexion contractures. It was also documented the resident's hands were contracted. The resident was hospitalized on 07/25/13 for non-healing pressure ulcers and re-admitted to the facility admission/start-up orders, dated 08/09/13. The facility admission/start-up orders, dated 08/09/13. documented the resident was to receive acetaminophen 640 mg every four hours as needed for pain and Norco 5/325 mg two tablets every four hours as needed for pain. A routine pain medication was not ordered on readmis	
FORM CMS-2567(02-69) Previous Versions Obsolete Event ID: NU5U11 Facility ID: NH7226 If continuation sheet Pa	

		ID HUMAN SERVICES					FORM	01/09/2014 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL		LE CONSTRUCTION		OMB NO, 0938-0391 (X3) DATE SURVEY COMPLETED		
375034		B. WING	_			C 12/17/2013		
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE	, ZIP CODE		
				Ł	6202 EAST 61ST STREET			
MAPLEWO	OOD CARE CENTER				TULSA, OK 74136			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	īΧ	(EACH CORRECTION CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRI ICLENCY)		(X5) COMPLETION DATE
F 309	resident had experier seven days in both le assessment revealed upon movement. A medication adminis 08/2013, documented Norco 5/325 mg, two On 08/24/13, the resi non-healing pressure the facility on 09/16/1 The facility admission 09/16/13, documenter receive Norco 7.5/32 needed for pain and The diagnosis descri included multiple pre- sclerosis, depression A nurse's note, dated documented, "Res transportationMulti [and] both hipsWoi treatRes in too mu [and] essess skin on A pain assessment doc her pain at six on a s documented the resi both knees and hips sharp and increased An annual essessment	Aration record, dated afration record, dated afration record, dated afration record, dated afration record, dated afration record, dated afration record, dated affation record, dated affatio	F	300	19			
	A nurse's note, dated documented, "Res transportationMulti [and] both hlpsWoi treatRes in too mu [and] assess skin on A pain assessment wo The assessment do her pain at six on a s documented the rest both knees and hips sharp and increased An annual assessme documented the rest	d 09/16/13 at 1:45 p.m., arrived at facility via hospital ple wounds to legs, both feet und nurse to assess [and] ch pain to ellow nurse to turn back [and] coccyx" was completed on 09/16/13, bumented the resident rated scale of one to ten. It was dent's pain was located in . The pain was described as with activities.						

FORM CMS-2587(02-99) Previous Versions Obsoleta

Event ID; NU5U11

Facility ID: NH7228

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 01/09/2014 APPROVED . 0938-0391
AND DI AN OC CODDECTION		(X2) MUL		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
375034			B. WING			C 12/17/2013		
NAME OF P	ROVIDER OR SUPPLIER			1 .	STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEW	OOD CARE CENTER			1	5202 EAST 61ST STREET FULSA, OK 74136			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRET TAG	XI	PROVIDER'S PLAN OF CORP (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AL DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 309	needed pain medicati revealed the resident rated at six on a scale documented the pain resident to sleep. A nurse's note, dated "Dr.[Name withheld to [increase] baclofer TID" On 10/03/13, the resi non-healing pressure the facility on 10/08/1 The diagnosis descri included multiple scle pressure ulcers on th A pain assessment wi The assessment revi diagnosis of multiple contractures and pre cause pain. It was di received routine and It was also document described the pain a and needles. The pain lower extremities, oc intermittent. The intr pain scale of one to resident's sleep. Re made the pain worse The facility resident- 10/08/13, document constant, severe pain	ion. The assessment is pain was frequent and e of one to ten. It was made it hard for the 09/20/13, documented, i) in the building [new order] in to QID, Flexeril 10 mg ident was hospitalized for e ulcers and re-admitted to 13. ption on re-admission erosis, depression, and he low back, hip, and heel. vas completed on 10/08/13. ealed the resident's scierosis and conditions of ssure ulcers that would likely ocumented the resident as needed pain medication. ted the resident had s dull, burning, tingling, pins ain involved both upper and courred daily, and was ensity was rated seven on a ten and affected the positioning and movement	F	309				

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FORM CMS-2567(02-99) Previous Versions Obsolute

Event ID: NU5U15

Facility ID: NH7226

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		D HUMAN SERVICES			FORM	: 01/09/2014 APPROVED . 0938-0391
AND DI AN OF CODDECTION		1	ECONSTRUCTION	(X3) DATE COMPI	LETED	
		375034	B, WING			C
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER		1	6202 EAST 61ST STREET TULSA, OK 74136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) Dompletion Date
F 309	Continued From page	ə 86	F 309	3		
	220 mg every day for	ient was to receive Aleve				
	200 mg one tablet ev	ders, dated 11/2013 dent was to receive Aleve ery day for pain and Norco ts every four hours as				
		rm, dated 11/2013 Jont received Norco 7.5/325 Jour hours as needed for				
	documented, "Proc monitor [sic] for any a if appropriateMedic call physician if no re medication as ordere and achieve her goa	lef is not obtained consult				
	documented the resi 220 mg every day fo	ders, dated 12/2013, dent was to receive Aleve r pain and Norco 7.5/325 mg r hours as needed for pain.				
	documented, "Nor Peg Tube Every 4 H a stash mark through	aton records, dated 12/2013, co 7.5-325 Tablet 2 Tabs Per rs As Needed" There was n the two in the ions of the Norco, and the				

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CENTER	SFOR MEDICARE &	D HUMAN SERVICES				FORM OMB NO	: 01/09/2014 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		le construction	(X3) DATE SURVEY COMPLETED C		
376034			B, WING			12/17/2013	
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER				6202 EAST 61ST STREET TULSA, OK 74136		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			-IX 3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page numeral "1" was write		F	30	90		
	through 12/09/13, rev resident requested, o	unt sheets, dated 12/01/13 realed documentation the n a daily basis, Norco ach tube feeding, at 9:00 4:00 p.m.					
		a.m., LPN #3 was observed re ulcer care to resident #3,					
	torso was twisted to t with both legs drawn	served to be severely and knees. The resident's he left from the waist down and crossed at the ankles t in areas creating high risk					
	The LPN stated the r administered pain me the wound care begin	edication 30 minutes prior to					
	The resident was as scale of one to ten.	ted to rate her pain on a She stated, "Eight."					
	spasms. When the L	able to relax due to muscle .PN would touch the begin having muscle spasms,					
		ion of the resident's lower ent would yell out, "Oh, Oh."					
	red, and her eyes we	ry flushed, her cheecks were ere wide. She had a grimace arful look when she knew l.					
		sident was asked if she had ation prior wound care. She					

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		D HUMAN SERVICES				FORM	01/09/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(C2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
375034			B. WING	-		12/17/2013		
NAME OF P	ROVIDER OR SUPFLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEW	OOD CARE CENTER				8202 EAST 61ST STREET TULSA, OK 74136		{	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(XS) CONFLETION DATE	
F 309	Continued From page stated, "Yes."	ə 88	F	309	9			
	effective. She stated	felt the pain medication was , "They tell me I take the ation they can give me, but I er one."						
		ever refused repositioning. nes. It hurts. They can't get						
	resident's pain medic administering wound	2 was asked if she felt the ation was effective when care. She stated, "She has a you touch or move her."						
		2 was asked how she knew ain when administering care. s."						
	resident was in pain. the medication aide of She stated the medic pain pill. She stated,	she did when she saw the She stated she would tell or reposition the resident. ation aide will give her a "She lets us move her but She stated, "She hates						
	She was asked what She stated, "Touchin	causes the resident pain. g and moving her."						
	resident's pain. She	she had told about the stated, "Everyone knows." charge nurses were aware.						
	She was asked if it a medication was effect resident's pain. She							

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