STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375568	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on record review, observation and interview, the facility failed to A. maintain a clean comfortable environment for three of three halls. the facility failed to maintain carpets and common areas free of offensive odors such as urine; and B. ensure clean linens were available for three (#20, 22, and #23) of three sampled residents reviewed for availability of linens. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 96 residents resided at the facility. Findings: A facility Floors policy, dated 12/2009, read in parts, .Floors shall be maintained in a clean, safe, and sanitary manner .All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures . Mop heads shall be washed with a disinfectant and rinsed well after each use . 1. A Grievance Form, dated 07/12/22, documented a grievance from a resident representative, regarding the carpet and smell on the southeast hall. The form documented the RDO had explained the carpet process to the representative. No resolution or satisfaction of the representative for the concern was documented. On 07/20/22 at 8:13 a.m., upon entry to the facility and walking down the center hall, the carpet was observed to have food crumbs and dark brown streaks all the way down the hall. The odor throughout the building was of old dirty carpet that had been made wet and left to mold. On 07/20/22 at 9:14 a.m., the resident council president was interviewed. The resident stated the carpet is dirty and nasty and they had heard the facility was going to pull it up. They stated they had not seen that happen. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/20/22 at 12:01 p.m., on the southeast hall, room [ROOM NUMBER] was observed to have a brown, thick, substance with clumps on the floor next to the bed and dirty linens piled up on the floor near the room door. Multiple flies were observed in the room, landing on the bed and dirty linen. Used gloves were observed folded into each other on the floor. The carpet under the bed, was observed to have been cut in a rectangular shape approximately a foot away from the bed, all the way around it. The odor coming from the room was of feces. On 07/20/22 at 12:03 p.m., CNA #3 entered room [ROOM NUMBER], donned gloves, picked up the dirty linen and took it to the hopper room. The CNA stated the resident was incontinent and did not like to wear briefs, and kept tearing them off. CNA #3 was asked why the dirty linen was on the floor. They stated because the resident needed to be cleaned up first. They stated normally it would be placed in a bag. The CNA stated the carpet was stained and had been for some time. On 07/21/22 at 1:17 p.m., the carpet in room [ROOM NUMBER] was observed to have been cleaned, the odor from the room was that of dirty mop water. On 07/21/22 at 3:16 p.m., this surveyor was invited to attend the resident council meeting. During the meeting a resident stated a concern about the carpet throughout the facility being dirty and smelling like urine. The resident stated the facility had promised it would be replaced and added, We will all be dead by the time it gets replaced. On 07/26/22 at 3:10 p.m., while walking down the southeast hall, an odor of urine was observed from the nurses station to the end of the hall. On 07/26/22 at 3:53 p.m., the RRN was asked about the carpet. The RRN stated the carpet was a work in progress. The RRN was informed observations of the cleaning of the carpet were noted but the smell remained. They stated the plan was to replace the carpet. No other information was provided. On 07/27/22 at 1:04 p.m., an observation was made of dirty linen on the floor, outside of room [ROOM NUMBER]. A very strong, pungent odor of urine was observed throughout the entire southeast hall. The odor was not observed to be coming from a particular location, it was pervasive throughout the facility on each hall. On 07/29/22 at 3:10 a.m., from outside of the door at the end of the southeast hall, the hall was observed to have trash bags on the floor by resident rooms. The hall was observed to have trash and used gloves on the floor and to be dirty. No lights were on and no staff were observed on the hall. On 07/29/22 at 3:35 a.m., observations were made on southeast hall of trash bags of soiled linen on the floor at resident doorways. Trash and used gloves were strewn about on the floor. A strong urine odor was present throughout the hall. Resident #23 was observed to yell, Help me, help me. from down the hall. Resident #23 was observed in their room with the bed sheet to be urine soaked and wadded up under the resident on her right side. The resident's brief was observed to be soiled, urine soaked, and wadded up at the foot of the bed. The resident stated they were cold as they were trying to cover themselves with a blanket. The resident's pajamas were wet and. LPN #6 was asked why the resident had no sheet on the bed. They stated the facility was probably out of linens. CNA #9 stated she was not aware the resident had a change in condition and required assistance. They stated the resident had been independent in going to the restroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/29/22 at 5:00 a.m., LPN #6 was asked if the nurse gave report to the CNAs. The LPN stated yes. The LPN was asked why the CNA was not aware of a change in condition with resident #23. The nurse stated they did not know, they must have forgotten to give that in report. The nurse was asked why trash and used gloves were on the floor and dirty linen left by the residents doors. The nurse stated one of the residents only allows the nurse to change them and the nurse laid the bag at the door for the aides to pick up on their next round. The nurse was told but there were multiple bags of trash and dirty linens on the hall. The nurse was asked why. The nurse stated they did not know why the aides had not picked them up on their rounds. The nurse was asked why the hall smelled of urine. The nurse stated they thought it was the carpet. The nurse was asked if they thought the bags of soiled linens contributed to the smell. The nurse stated yes they should have picked those up. The nurse was asked why resident #23 was soaked in urine and feces. The nurse stated the aide stated they did not know the resident had a change of condition. The nurse was asked if they gave report to the aides. The nurse stated yes. The nurse was asked why then did the aide not know of the change of condition. They nurse stated they must have forgotten to mention it. On 07/29/22 at 5:05 a.m., resident #25 stated their room floods when it rains. They stated the air conditioner leaks water and the room floods. The air conditioner cover was observed to be off, a blanket was under the unit soaked with water. The water was pooling under the bed closest to the door where the resident sleeps. On 07/29/22 at 5:10 a.m., NA #10 was asked about the flooding in room [ROOM NUMBER]. They stated the facility floods often, facility is aware, the maintenance employee was called and was at the facility. On 07/29/22 at 5:15 a.m., maintenance #1 was in the maintenance office and asked about the flooding at the facility. They stated this was the first time since they had been here in three months. They stated a piece of screen came off of the outside of the air conditioner unit for room [ROOM NUMBER]. They stated they were able to screw it back on between downpours. They stated the conference room was flooded as well. On 08/03/22 at 5:02 p.m., there was a strong urine odor throughout the Southeast hall and in room [ROOM NUMBER]. On 08/03/22 at 5:09 p.m., a urine soaked adult brief was observed under the bed in room [ROOM NUMBER], a brown stain was also observed on the carpet. On 08/03/22 at 5:17 p.m., room [ROOM NUMBER] had a strong urine odor present. On 08/03/22 at 5:40 p.m., the strong urine odor remained in the Southeast hall. On 08/03/22 at 5:42 p.m., the staff delivered the evening meal to room [ROOM NUMBER]. The staff did not address the adult brief under the bed. On 08/03/22 at 6:10 p.m., LPN # 3 was asked about the adult brief under the bed in room [ROOM NUMBER]. LPN #3 stated the adult brief was soaked with urine. LPN #3 was asked about the brown stain on the carpet. LPN #3 stated it could be from feces. LPN #3 stated the staff should have removed the adult brief from the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/4/22 at 2:00 p.m., there was a strong nauseating odor throughout the facility that smelled like raw sewage. On 08/04/22 at 7:59 a.m., CNA #1 was asked how long the urine odor had been present on the Southeast hall. CNA #1 stated they thought it was from the carpet and it had smelled like urine for at least three to four months. CNA #1 stated the carpet was shampooed but it did not get rid of the smell. On 08/04/22 at 6:30 p.m. the administrator was asked about the condition of the carpet and environment. The administrator made no comment regarding the environment. 36191 2. A facility Bedrooms policy, dated 05/2017, read in parts, .All residents are provided with clean, comfortable .bedrooms that meet federal and state requirements .Each resident is provided with .bedding that is clean, in good condition . Resident council meeting minutes were reviewed. The following concerns were documented: Resident council meeting minutes, dated 01/06/22, read in part, .There are no lines [sic] for our beds . Resident council meeting minutes, dated 02/10/22, read in parts, .There are no towels and washclothes [sic] for them to use .We are working on this to make it better . Resident council meeting minutes, dated 06/07/22, read in parts, .Laundry .need more linens . Resident council meeting minutes response, dated 07/25/22, read in parts, .When will we get more [NAME] in laundry unless 1 overnight person to help get caught up .Response/Actions taken by Department to Resolve Issue .identified .It is being addressed . A July linen inventory sheet, documented the facility census was 110 and the following linens were available: Flat sheet: 88 Fitted sheet: 97 Pads: 26 On 07/29/22 at 3:35 a.m., Resident #23 was observed in bed without sheets under the resident. The sheets were found soaked with urine, wadded up underneath Resident #23's right side. Resident #23 stated they were cold. LPN #6 was asked about sheets for the bed. LPN #6 stated they were probably out of linens. Five towels, four pillow cases, one blanket, and one sheet were located on the Southeast hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/29/22 at 4:05 a.m., the North hall had two towels, one draw sheet, and two blankets. LPN #7 was asked if they had enough linens for the residents. They stated they usually had to go look for sheets and gowns. On 07/29/22 at 5:00 a.m., LPN #6 was asked about the linen supply on the Southeast hall. LPN #6 stated they did not usually have many linens and the CNAs would have to go to another hall or to the laundry room to get linens. The center hall had eight sheets, three fitted sheets, three pillow cases, two blankets, four gowns, two draw sheets, and twelve towels. On 07/29/22 at 5:25 a.m., the laundry room had 14 clean towels, seven clean blankets, three draw sheets, one fitted sheet, one bath blanket, and three gowns. Laundry was observed in the washer and dryer. On 08/03/22 at 5:09 p.m., Resident #20 was observed in their bed with no bottom sheet on the bed. Resident #20 was asked if they needed a sheet for their bed. They stated, Yes. On 08/03/22 at 5:15 p.m., Resident #22 was observed in the bed without a fitted sheet on the bed. On 08/03/22 at 5:17 p.m., Resident #23 was observed in their bed without a fitted or flat sheet on the bed. On 08/03/22 at 5:18 p.m., CNA #2 was asked why the residents did not have sheets on their beds. CNA #2 stated they did not have any linens. CNA #2 stated they had come to work at 3:30 p.m., and noticed a lot of the beds did not have sheets on them. CNA #2 was asked where the linens were stored for the Southeast hall. The two linen closets were observed with CNA #2. No linens were observed in the linen closets. On 08/04/22 at 7:50 a.m., one linen closet on the Southeast hall had one pillow case, one gown, one bath blanket, a stack of towels. The other linen closet located on the Southeast hall contained no linens. No sheets were observed in the linen closets on the Southeast hall. On 08/04/22 at 8:05 a.m., CNA #1 was asked about the empty linen closets on the Southeast hall. CNA #1 stated they spoke to the housekeeping/laundry manager about the linen and they were supposed to have ordered more linen. CNA #1 was asked how long the linen had been low. CNA #1 stated a month or two. On 08/04/22 at 8:10 a.m., the laundry room was observed to have one clean fitted sheet, one clean pillow case, three clean bath blankets, and nine clean towels. Laundry aide #1 was asked where the linens were located. Laundry aide #1 stated they were in the washer and dryer. Laundry aide #1 was asked if there were sheets in the cabinet labeled sheets. Laundry aide #1 stated no. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/04/22 at 9:59 a.m., the laundry supervisor stated there were not enough sheets for all of the residents. The laundry supervisor stated they did a linen audit at the first of every month. The laundry supervisor stated the inventory done at the beginning of July 2022, identified the facility was short on linens and the administrator was notified. The laundry supervisor stated linens were ordered three weeks after the administrator had been notified of the linen inventory. The laundry supervisor stated the laundry aide was washing sheets at this time. Four clean fitted sheets and five clean flat sheets were observed in the laundry area. The laundry cabinets labeled sheets were observed. No sheets were in the cabinet. The laundry supervisor stated they were not able to order the linens, the administrative staff ordered the linens based on the inventory done each month.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 07/26/22 at 5:31 p.m. an Immediate Jeopardy situation was identified and verified through the Oklahoma State Department of Health (OSDH) regarding neglect of the facility to ensure medical social services for Resident #10. Resident #10 presented to the facility a request from his cancer specialist, for a dental evaluation for clearance to begin chemotherapy and radiation to prevent the spread of cancer, on admission and two follow up visits on 04/05/22 and 07/18/22. The requests were unfulfilled by the facility. Resident #10 went five months without the requested dental evaluation. This neglect prevented Resident #10 from beginning his chemotherapy and radiation treatment and put the resident at increased risk for the spread of cancer. An acceptable Plan of Removal (POR) was submitted on 07/27/22 at 10:53 a.m. with notification made to the Administrator at 10:54 a.m. The POR was provided as follows: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on July 26th, 2022, for neglect and Medical social needs. Action Item: All residents will be reviewed for medical social services's needs. Interviews with the residents/responsibility[sic] party to assess for immediate medical social service's[sic] needs. Record review will be completed within 48 hours to assess medical social service needs. Person Responsible: Nursing and administration Timeline for completion: 7/27/22 by 1600 cst Action Item: Resident number ten will be scheduled for a follow up dental appointment for clearance related to chemotherapy. Person Responsible: Nursing and Administration scheduled his dental appointment for 8/23/22. The center is continuing to try to schedule an appointment sooner. The center will notify the Oncologist that the dental appointment has been scheduled and the the center continues to try to schedule an earlier appointment. Timeline for completion: 7/27/22 by 1600 cst Action Item: Medical Social Services will be monitored by Nursing and Administration until a Director of Social Services is in place. Monitoring will consist of the nurse managers reviewing all appointment follow up paperwork. Appointments will be made and transported by the transportation position. The Administrator and the nursing administration will review the completion of the process. Person Responsible: Administration/DON/Regional Nurse Manager Timeline for completion: 7/27/22 by 1600 cst (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: The Administrator/DON/ Corporate resource social worker will re- inservice all staff on appointment process, follow up services required, neglect and documentation/notification of these services. Person Responsible: Administrator/DON/ Corporate resource social worker Timeline for completion: 7/27/22 by 1600 cst On 07/27/22 at 5:21 p.m., the immediacy was removed leaving the deficient practice at a level of isolated harm. Based on record review, observation, and interview, the facility failed to ensure medical needs were not neglected for one (#10) of six residents sampled for neglect. The facility failed to ensure Resident #10 was assessed and reviewed for clearance to receive chemotherapy and radiation to reduce the risk of the spread of cancer. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 96 residents reside at the facility. findings: Resident #10 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of right kidney, Leukemia, and cutaneous squamous cell carcinoma of right ear (skin cancer). A Progress Note, dated 02/22/22, documented social services had left messages with the Indian clinic and the cancer specialist office regarding authorization for radiation treatment with no response. The note documented resident #10's case worker, with the Indian Nation had informed the facility, the [NAME] had done an authorization, and another message was left for the cancer specialist. There was no documentation in the clinical record an appointment had been scheduled or that Resident #10 had been evaluated by a dentist. A Progress Note, dated 03/22/22, read in part, .No outside referrals needed at this time. The note was signed by social services. No other notes were documented by social services. A document titled, Oklahoma Cancer Specialists and Research Institute Established Patient History and Physical, dated 04/05/22, read in parts, .Patient presents today for re-evaluation for radiation therapy anterior review results of most recent PET scan. He has not yet undergone his dental evaluation .Dental evaluation ASAP . There was no documentation in the clinical record Resident #10 had the dental evaluation to be cleared for chemotherapy, or that an appointment had been scheduled. A document titled, Oklahoma Cancer Specialists and Research Institute Established Patient History and Physical, dated 07/18/22, read in parts, .Leukemia 2014 .Cutaneous squamous cell carcinoma of the right ear S/P surgical resection with neck dissection 11/1/2021 .Plan .Waiting on dental clearance to start further adjuvant therapy .Follow-up in 1 month . There was no documentation in the clinical record Resident #10 had the dental evaluation to be cleared for chemotherapy, or that an appointment had been scheduled. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/20/22 at 10:05 a.m., resident #10 stated they had not been to the dentist to be cleared for chemotherapy and radiation. Resident #10 stated they had surgery to remove the skin cancer near their ear prior to entering the facility and was to be cleared for treatment by a dentist. The resident stated appointments had been scheduled by their representative and canceled because the facility did not have transportation to get them to the dentist. On 07/21/22 at 10:11 a.m., resident #10's representative stated the number of dental appointments that had been scheduled and canceled were three. The representative stated they were surprised Resident #10 was able to get to the cancer specialist appointment on July 18th because the facility told them they did not have transportation. On 07/21/22 at 10:33 a.m., LPN #3 stated Resident #10 had been to the cancer specialist on the 18th. They stated they only knew because the resident had informed them of the visit. The LPN stated residents should be signed out when leaving the facility. The LPN checked the sign out book, but resident #10 was not signed out that day. LPN #1 referred to the nurse that worked the 18th. On 07/21/22 at 10:45 a.m., LPN #4 stated they had worked Resident #10's hall the 18th, but did not remember if the resident went out of the facility. The LPN stated the resident would have been signed out by transportation. The LPN stated the transportation person was new and may not have signed out the resident because it was their first day. LPN #4 was asked if there would be any other documentation of Resident #10's visit. They stated no. LPN #4 was asked who scheduled the resident appointments. They stated social services scheduled appointments. The LPN was asked who scheduled appointments when there was no social services. They stated they did not know. On 07/21/22 at 11:00 a.m., the medical records person confirmed Resident #10 was taken to an appointment on the 18th. MR was asked where it was documented. They stated the nurse was to enter a progress note. MR was asked if Resident #10 had returned with any records of the appointment. They stated yes but they had not scanned it into the system yet. There was no documentation in the clinical record the resident had an appointment on the 18th. On 07/26/22 at 10:37 a.m., MR stated nobody was doing social services. They stated themselves and the HR person had been tag teaming social services for the past several months since there was no social services person. The MR staff person was asked if they were aware Resident #10 had a follow up appointment in a month with their cancer specialist. They stated no, after they scanned in the paperwork it was given to the nurse who was to notify of any appointments or follow ups and chart on it. There was no documentation in the clinical record the resident had a follow up appointment or that an appointment had been scheduled. On 07/26/21 at 12:31 p.m., Resident #10's cancer specialist stated resident #10's care and treatment had been compromised due to not getting their treatments for cancer post surgery. The doctor stated it had been four months since a dental clearance was requested. The doctor stated the skin cancer had been removed but without chemotherapy/radiation it could come back. The doctor stated they like to do treatments within one to two months after surgery. The doctor stated delaying the treatment had put resident #10 at risk for the cancer to return and spread. The doctor stated it was unknown if the cancer had spread at this point in time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/26/22 at 3:53 p.m., the RRN #2 was asked how long the social services position had been empty. They stated one had been hired, but only worked one day and quit last Wednesday. They stated the corporate social worker had been in and out of the facility. The RRN was asked who had assisted with social services when the corporate social worker was not present. They stated, I'm assuming MR was helping. Other than that, I don't know. The RRN was asked who documented or scheduled follow up appointments. They stated the nurse should document on the resident's calendar. The RRN was asked if their system worked. They stated, We know it's broken.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 35749 Based on record review and interview, the facility failed to ensure dependent residents received scheduled baths for three (#4, 10 and #14) of 10 sampled residents reviewed for ADLs. The Resident Census and Conditions of Residents report, dated 07/20/22, documented 25 residents were dependent for bathing. Findings: A Bathing policy, revised on February 2018, read in part, .The purpose of this[sic] procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin . Documentation .The date and time the shower/tub bath was performed . 1. Resident #4 had diagnoses which included arthritis of the right knee. A resident assessment, dated 06/17/22, documented the resident required extensive assistance of two for bathing. ADL care reports, dated June and July 2022, documented the resident had not received a bath since 07/28/22. On 08/03/22 at 5:35 p.m., Resident #4 was asked if there was adequate staff to meet their needs. They stated, No. They stated, Bed baths and hair washing is hard to get done. They were asked how frequently they would like to be bathed and have hair shampooed. They stated twice weekly. They were asked the last time they had been bathed and hair washed. They stated on 07/28/22. On 08/04/22 at 10:35 a.m., the DON was asked for resident #4's bathing schedule. They stated the resident was scheduled for baths on Monday, Wednesday, and Friday. They were shown the June and July 2022 ADL reports and asked if the resident had received bathing as scheduled. They stated, It doesn't appear they've been done. 41809 2. Resident #10 was admitted to the facility with diagnoses that included chronic pain and multiple myopathies. Review of ADL care reports and shower sheets provided by the facility indicated the resident received three showers since admission in February. Resident #10's Care Plan, revised 07/05/22, documented the resident preferred showers three times a week on Tuesday, Thursday, and Saturday on the first shift. Resident #10's initial resident assessment, dated 02/13/22, documented the resident required hygiene/bathing assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375568	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/20/22, at 10:05 a.m., resident #10 was asked if they received baths/showers as preferred. The resident stated no they showered daily at home. Resident #10 stated at the facility they would settle for three times a week but had not been bathed in a month and their sheets had not been changed in five months. On 07/29/22 at 1:18 p.m., CNA #6 was asked if the facility had enough staff to meet the needs of residents. The CNA stated no. CNA #6 was asked what did not get done. They stated showers. On 07/29/22 at 2:00 p.m., CNA #11 was asked if the facility had enough staff to meet the needs of the residents. The CNA stated no. CNA #11 was asked what did not get done. They stated cleaning resident rooms, changing resident linen, and showers. 3. Resident #14 was admitted to the facility with diagnoses that included morbid obesity and displaced intertrocanteric fracture of left femur. Review of ADL care reports, dated July 2022, revealed the resident received baths/showers three times out of 10 opportunities. Resident #14's Care Plan, revised 07/04/22, documented the resident required extensive assistance with ADL care and bathing. Resident #14's initial resident assessment, dated 07/10/22, documented the resident required extensive assistance with the help of two staff for bathing. On 07/27/22 at 1:50 p.m., resident #14 was asked how often they received a shower. The resident stated they did not receive a shower for 21 days after admission. They stated their first shower was on 07/25/22. On 07/29/22 at 1:18 p.m., CNA #6 was asked if there were enough staff to meet the needs of residents. They stated no. The CNA was asked what care did not get provided. The CNA stated showers. On 07/27/22 at 2:15 p.m., CNA #4 was asked when resident showers were scheduled. They stated showers for residents in A bed were scheduled on even dates, and B bed residents were scheduled on odd dates. The CNA stated residents were scheduled between two and four showers per week. CNA #4 was asked who was responsible to provide the showers. They stated the shower aide but on North hall the CNA's did their own. CNA #4 was asked if they had provided a shower for Resident #14. They stated they had given the resident a shower on Monday 07/25/22. They were asked where it was documented. CNA #4 stated on a shower sheet. On 08/04/22 at 5:15 p.m., the DON was asked why baths were not happening. They stated the situation would need to be looked into.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 07/28/22 at 7:05 p.m., an Immediate Jeopardy (IJ) situation was identified and verified with the Oklahoma State Department of Health (OSDH). The facility failed to ensure pressure ulcer management to promote healing and prevent new or worsening pressure ulcers for resident #15. The wound nurse failed to follow physician orders and failed to provide pressure wound treatments daily as ordered by the physician for Resident #15. Notification of IJ was provided to the facility at 7:13 p.m. with a request for a Plan of Removal. On 07/29/22 at 12:15 p.m., an acceptable plan of removal was received as follows: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on July 28th, 2022 for Pressure Ulcer and Pain Action Item: All residents will have a skin assessment completed. All Residents with wounds will be assessed/reassessed and wound assessment documented as well as review of treatment orders resident specific. Physician is evaluating all residents pain management. All residents will be assessed/reassessed for pain and provided subsequent pain management per physician recommendations and will be provided resident specific treatment. Assess and review interventions. Staff will audit wound care treatments per shift for completion of treatment, pain assessment, interventions needed and physician notification as needed to address wounds and pain concerns. Person Responsible: Nursing Timeline for Compliance: 7/30/22 8:00pm CST Action Item: Resident #15 was sent to Emergency Department for Treatment and evaluation of wounds and pain. A low air loss mattress will be in place upon his return and to any resident that has been identified as needing a low air / treatment specific mattress. Note of noncompliance: Resident is non compliant with diabetic treatment; resident is non-compliant with Hemodialysis. Person Responsible: Nursing Timeline for compliance: 7/29/22 5:00pm CST Action Item: All Nurses will receive an in-service on pressure ulcers, interventions, assessments, and treatments. All direct care staff will be in-serviced on pain recognition, policy and procedures related to pain recognition, assessment, and appropriate intervention. Wound Treatment Nurse will be educated on how to assess for pain and proper interventions of a resident experiencing pain during wound treatments by the Corporate Resource Nurse. Person Responsible: Corporate Resource Nurse/DON Timeline for Compliance: 7/30/22 8:00pm CST (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediacy was removed for 08/04/22 at 3:20 p.m. when the last resident skin assessment was completed, leaving the deficient practice at an isolated harm. Notification of immediacy removal date and time made to the administrator on 08/04/22 at 4:24 p.m. Based on record review, observation, and interview, the facility failed to assess, monitor, obtain and provide pressure wound treatments to prevent infection/maggots for two (#11 and #15) of eight residents reviewed for pressure ulcers. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 11 residents with pressure ulcers resided at the facility. Findings: A facility policy titled, Wound Care, revised June 2022, read in parts, .guidelines for the care of wounds to promote healing .Verify that there is a physician's order for this procedure .Review the resident's care plan to assess for any special needs of the resident .resident may have PRN orders for pain medication to be administered prior to wound care . 1. Resident #15 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer to buttock unstageable, end stage renal disease, peripheral vascular disease, and diabetes type two. Resident #15's Care Plan, revised 04/21/22, documented a category as pressure ulcer and listed four wounds; Unstageable to right thigh/lower right buttock,left buttock,Stage 3 Sacrum. The care plan documented a goal that the resident's wounds will decrease in size, with five interventions in place. The interventions listed were: follow facility skin care protocol, preventative measures, report to charge nurse any skin redness or breakdown immediately, treatment as ordered, and turn and reposition every two hours and prn. The resident's care plan did not address resident pain during the wound treatments or prior to wound treatments. The number of wounds and locations of wounds were incorrect and incomplete. A [NAME] Initial Wound Evaluation and Management Summary, dated 04/21/22, documented wound site one, a stage four pressure wound of the left ischium, with moderate purulent drainage and measurements (length x width x depth) 9.9 x 5.4 x 2 cm. The wound covered a surface area of 53.46 cm squared with undermining of 7 cm at 7 o'clock with 100% necrotic tissue. The wound was documented to have an odor. Wound site two, an unstageable pressure wound of the right ischium, with light sero-sanguinous drainage and measurements 5.7 x 7 x 0.2 cm. The wound covered a surface area of 39.90 cm squared with no undermining documented and 100% necrotic tissue. This wound was documented to have an odor. Wound site three, an unstageable, full thickness pressure wound of the sacrum, with moderate sero-sanguinous drainage and measurements 4.4 x 4.6 x 0.3 cm. The wound covered a surface area of 20. 24 cm squared with no undermining documented. The wound was documented to have an odor with 70% slough and 30% granulation of the wound bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound site four, an unstageable, full thickness pressure wound of the left hip, with light sero-sanguinous drainage and measurements 5.5 x 5.3 x not measurable cm. The wound covered a surface area of 29.15 cm squared with no odor or undermining documented. The wound was documented to be 100% thick devitalized necrotic tissue. The wounds #1 through #4 were documented to have a dressing treatment plan to apply Dakins (sodium hypochlorite) solution twice daily for 30 days and to apply a sterile gauze sponge twice daily for 30 days then apply a Dakins soaked gauze, wet to moist, twice daily. A secondary dressing of ABD pad twice daily for 30 days. Wound site five, an unstageable, full thickness, pressure wound of the left heel, with light sero-sanguinous drainage and measurements 5.5 x 6.8 x not measurable cm. The wound covered a surface area of 37.40 cm squared with an odor. The wound was documented to have 90% thick adherent black necrotic tissue and 10% thick adherent devitalized necrotic tissue. The dressing plan for the wound was documented as to apply Santyl once daily for 30 days, cover with gauze island border dressing once a day for 30 days. Recommendations to off-load wounds, reposition per facility protocol, and provide a low air loss mattress. No other [NAME] wound evaluations or visit notes were provided. The wound doctor's wound treatment orders and recommendations were not followed or put in place. Resident #15 was sent out to the hospital 04/22/22 due to a low blood pressure reading of 88/54. The resident did not return to the facility until 05/19/22, due to wound infections, per hospital discharge summary and facility progress notes. A Progress Note, dated 05/22/22 at 8:58 p.m., documented Resident #15 was seen by the wound doctor and the LPN. The note documented the LPN observed the resident was not able to answer questions due to an altered mental status. The note documented the resident was under three blankets and blood was pooling under the wound vacuum dressing, when the dressing was removed, blood was pulsating from multiple areas. The wound doctor ordered the resident be sent to the emergency room for evaluation. No documentation was provided of the wound doctors visit that day. A hospital document titled, ED to Hosp-Admission, dated 05/23/22, read in parts, .Acute blood loss anemia . Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present .Osteomyelitis, unspecified site, unspecified type .Sacrum: 7 x 10 x 2.5 cm to fascia [length x width x depth], L trochanter: 9. 5 x 5 x 5.5 cm to bone, L ischium: 10.5 x 8 x 4 cm to bone (biopsy and cx), R ischium: 11 x 5 x 3.5 cm to fascia .Portion of bone from left ischium for pathology and culture . Resident #15's MAR, dated June 2022, documented Resident #15 was in house 06/16/22 to 06/20/22. The MAR documented to assess and document if wound dressings were clean, dry, and intact every shift. The start date of the assessment was 06/20/22, the order was open ended. The MAR documented a sacrum wound treatment and dressing assessment were ordered to start 06/19/22. No orders were in place for wound treatments from 06/16/22 until 06/19/22. The wound treatment orders for the left posterior thigh, left buttock, and left shin were not ordered until 06/20/22. A Progress Note, dated 06/16/22 at 12:05 a.m., documented Resident #15 returned to the facility skilled with a diagnosis of acute anemia. (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note, dated 06/19/22 at 10:33 p.m., documented Resident #15 had received wound care provided by the wound nurse and an RN. A Progress Note, dated 06/19/22 at 10:41 p.m., documented IV antibiotics arrived to start in the morning. A Progress Note, dated 06/20/22 at 4:52 a.m., documented received IV antibiotics. A Progress Note, dated 06/20/22 at 11:43 a.m., documented Resident #15 was send to the hospital to be dialized. A hospital document titled, ED to Hosp-Admission, dated 06/20/22, read in parts, .Chief complaint needs dialysis .Patient not able to provide history .the patient only moans answers .did respond to the positive when asked about abdominal pain .CT abdomen pelvis without contrast .Pelvis .large bilateral soft tissue defects consistent with decubitus ulcers overlying both ischium, coccyx and the left greater trochanter. Cortical bone is exposed to the air at each of these sites .Osteomyeitis cannot be excluded on the basis of this examination .On initial laboratory test however he is noted to have a white blood cell count of 24, uptrending from his prior on discharge .also noted to have tachycardia with a heart rate of 116 .CT of abdomen pelvis was performed which shows findings as above with severe decubitus ulcers in signs of concerning for osteomyelitis .Admit to inpatient status .for the following reasons: Transient hypotension in the setting of end-stage renal disease with dialysis, recent hospitalization for osteomyelitis and multiple decubitus ulcers requiring IV antibiotics, follow-up lab, follow-up cultures, serial clinical exams necessitate inpatient hospitalization to monitor for symptoms condition, loss of function, loss of life .Sacrum: 15 x 11.5 x 1.3 cm; tunnel at 12:00 to 2 cm;depth to fascia/bone (probable osteomyelitis) over lower sacrum, L trochanter: 10.5 x 5.5 x 2.5 cm; tunnel at 12:00 14 cm; depth to necrotic fascia and bone (osteomyelitis), large purulent drainage cultured, Left ischium: 14 x 7 x 2.5 cm; tunnel at 12:00 7 cm; depth to bone (osteomyelitis), Right ischium: 10 x 5.5 x 2.2 cm, tunnel at 12:00 8 cm; depth to fascia .Extensive wounds, worsening with current measure; ischial wounds and sacral wounds nearly confluent at SQ level with intact skin bridges; diffuse coagulapathic type bleeding from surfaces due to antiplatelet use .Is been about 5 weeks since last operation and wounds are clinically deteriorating . A Facility Wound Summary Report, dated 06/26/22 to 07/26/22, documented Resident #15 wounds as identified on 06/16/22 with measurements (L x W x D) (cm): a. Sacrum 6.5 x 13.5 x 4 with most recent observation date/time as 06/16/22 8:29 a.m. b. Right hip 9.4 x 9.3 x 5.8 06/16/22 8:36 a.m. c. Right buttock 9.2 x 11.1 x 5.7 06/16/22 at 8:32 a.m. d. Left buttock 7.5 x 7.2 x 4 06/16/22 at 8:31 a.m. e. Left heel 8 x 7.5 06/19/22 6:57 p.m. f. Left shin 9 x 2.3 06/16/22 at 6:56 p.m. Wound nurse notes, dated 07/27/22, documented Resident #15's wounds as: (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Sacrum 8.7 x 15.7 x 6.4 with tunnel at 12:00 2 cm b. Right hip 10.8 x 11.4 x 6.4 c. Right buttock 10.8 x 12.9 x 7.1 d. Left buttock 8.2 x 9.4 x 6.7 e. Left heel 6 x 7.25 f. Left shin 8 x 3.25 No other assessments were provided by the facility. A Progress Note, dated 07/19/22 at 2:40 p.m., documented Resident #15 returned to the facility. Resident #15's Physician's Orders, dated 07/19/22, documented to administer Santyl (a debridement wound treatment) 250 u/gm one application once a day; a wound treatment order: Left foot (left 1st, 2nd, 3rd toe) Clean with normal saline/wound cleanser, apply: providine cover with primary dressing: gauze, secure with Kerlix (a brand of roll gauze) and tape once a day; a wound treatment order: Left shin, clean with wound cleanser/normal saline, apply: Santyl, cover with primary dressing: soft silicone dressing once a day; a wound treatment order: unstageable pressure injury to left heel, clean with normal saline/wound cleanser, apply: Santyl, cover with primary dressing: soft silicone bordered heel dressing, secure with Kerlix and tape once a day; and a wound treatment order: left ischial and left surgical trochanter, clean with normal saline/wound cleanser, apply: Santyl, cover with primary dressing: soft silicone dressing once a day. Resident #15's Physician's Orders, dated 07/20/22, documented: a wound treatment order: left posterior thigh, clean with normal saline/wound cleanser, apply: Santyl, cover with primary dressing: gauze, then soft silicone bordered dressing once a day; a wound treatment order: right hip/ischium, clean with wound cleanser/NS apply: Santyl, cover with primary dressing: silicone bordered dressing once a day; a wound treatment order: sacrum, clean with Vashe wound cleanser/normal saline, apply: Santyl, cover with primary dressing: Kerlix roll gauze and soft silicone bordered dressing once a day; to administer daptomycin 500 mg IV once a day every other day to end on 07/21/22; and documented to administer meropenem 0.9% sodium chloride piggyback; 1 gram/50 mL; IV once a day with a stop date of 07/21/22 for a diagnosis of sepsis. (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #15's treatment administration record, dated 07/01/22 through 07/28/22, documented the resident was in house from 07/19/22 to 07/28/22. The daptomycin was not administered as ordered on 07/20/22, with no explanation provided. The date of 07/20/22 was blank. The treatment record also had blanks for the meropenem on the dates of 07/20/22 and 07/21/22 with no explanation provided. The Santyl order was documented as not done four out of eight opportunities. The reasons provided were blank, drug/item unavailable, or dialysis. The wound treatment order for the left posterior thigh was documented as six missed opportunities out of eight. The reasons/comments were documented the same as above. The wound treatment order for the left buttock ordered to be completed daily appeared on the TAR twice for the dates the resident was present in the facility. Both dates were documented as completed on 07/19/22 and 07/20/22. The wound treatment order for the left foot, left shin, right hip/ischium, sacrum, and left ischial and left surgical trochanter, were all documented as seven missed opportunities out of eight. The wound treatment pain evaluation, ordered daily, was documented as five missed opportunities out of ten, with five dates documented with a pain value of zero on a scale of zero to ten. On 07/28/22 at 12:28 p.m., the wound nurse was observed to provide pressure wound treatments to resident #15's six pressure ulcers. Upon entry to the room, the wound nurse failed to assess for pain of the resident prior to administering the treatments. The resident was observed to not be on a low air loss mattress to prevent pressure ulcers or promote healing. The resident was observed to be flat on his back with nothing to prevent the heel from being in contact with the mattress. Upon removal of the dressings the dates of the removed dressings were observed to be 07/26/22. The wound nurse was observed to not clean the wounds in an aseptic manner or with regard to the residents comfort. The nurse cleaned the heel quickly and in a rough manner in continuous circles with gauze. The left lateral shin wound was cleaned roughly, with gauze moving quickly and continuously from left to right and right to left. The wound nurse was not observed to change gloves between removing a dirty dressing, cleaning the wounds, or applying a new dressing. Observations were made of the resident expressing pain, both verbally and non-verbally during the dressing changes that went unaddressed by the wound nurse until the resident was rolled to the left side and stated to the nurse, This hurts me. The wound nurse then stated to the resident, I know, I'll let the nurse know when I leave to see if we can get some pain meds for you. (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Physician's Order, dated 05/06/22 to 07/22/22, documented a wound treatment order: left medial ankle, apply skin prep daily once a day morning. A Physician's Order, dated 05/10/22 to 07/22/22, documented a wound treatment order: left lateral calf, clean with normal saline/wound cleanser, apply alginate calcium, cover with bordered island gauze once a day morning. A Physician's Order, dated 05/10/22 to 07/22/22, documented a wound treatment order: right medial calf, clean with normal saline/wound cleanser, apply alginate calcium and collagen sheet with silver, cover with gauze island dressing, once a day morning. A Physician's Order, dated 05/15/22 to 07/22/22, documented a wound treatment order: right lateral calf, clean with normal saline/wound cleanser, apply: alginate calcium, collagen powder, apply once daily for 30 days: moisten lightly with normal saline, cover with primary dressing: border island dressing once a day morning. A Physician's Order, dated 06/16/22 to 07/22/22, documented a wound treatment order: left, lateral knee, clean with normal saline/wound cleanser, apply: collagen sheet and calcium alginate, cover with primary dressing: foam dressing once a day on Mon, Wed, Fri morning. A Physician's Order, dated 06/16/22 to 07/22/22, documented a wound treatment order: left lateral calf, clean with normal saline/wound cleanser, apply alginate calcium AG, cover with foam dressing, once a day on Mon, Wed, Fri; shift 1. A Physician's Order, dated 06/16/22 to 07/22/22, documented a wound treatment order: sacrum, apply barrier cream every shift am pm. A Physician's Order, dated 07/03/22 to 07/22/22, documented a wound treatment order: right bottom foot, clean with normal saline/wound cleanser, apply Santyl, cover with adhesive gauze once a day shift 1. Resident #11's TAR, dated 07/01/22 to 07/31/22, documented the resident was in house 07/01/22 to 07/19/22 and 07/19/22 to 07/22/22. The wound treatment to the right bottom foot, ordered daily, was documented as 13 missed opportunities out of 19. The wound treatment to the left lateral knee, ordered Monday, Wednesday, and Friday was documented as six missed opportunities out of seven. The wound treatment to the left lateral calf, ordered Monday, Wednesday, and Friday was documented as five missed opportunities out of seven. The wound treatment to the right calf, ordered Monday, Wednesday, and Friday was documented as five missed opportunities out of seven. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375568	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility reported incident form, OSDH 283, dated 07/20/22 documented allegations of neglect and read in part, .maint director did not show up to work this morning and sent a text saying someone had maggots in his wounds and this was why he was leaving . Review of hospital medical records titled, ED to Hosp-Admission (Current), dated 07/22/22, read in parts, . Clinically the patient has numerous bilateral lower extremity ulcerations most notably in necrotic right plantar forefoot ulceration initially with visible maggots that were washed out and left medial ankle ulcerations to level of bone with concern for underlying osteomylitis [bone infection] .Patient is at risk of major limb amputation due to this presentation. We will consider bilateral lower extremity ulcer debridements with bone biopsies to guide long-term IV antibiotic therapy per infectious disease recommendations if positive for osteomylitis as long as his limbs are deemed viable/salvageable from a peripheral perfusion standpoint based on cardiology's recommendations . On 08/04/22 at 5:56 p.m., the DON was asked what their expectations were of the wound nurse when performing pressure wound treatments. The DON stated they expected the wound nurse to follow the physician orders and infection prevention protocol. The DON was asked if wound treatments were occurring if maggots were found in a residents wound. They stated no.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41809 On 07/28/22 at 7:05 p.m., an Immediate Jeopardy (IJ) situation was identified and verified with the Oklahoma State Department of Health (OSDH). The facility failed to ensure the pain management of resident #15 during the treatment of pressure wounds. The wound nurse failed to assess resident #15's pain prior to administering pressure wound treatments to the resident's six wounds. During the pressure wound treatments the resident displayed verbal and nonverbal expressions of pain and the wound nurse failed to stop the treatment and treat the resident's pain. Notification of IJ was provided to the facility at 7:13 p.m. with a request for a Plan of Removal. ***The immediacy was removed for 08/04/22 at 3:20 p.m. when the last resident skin assessment was completed, leaving the deficient practice at an isolated harm. Notification of immediacy removal date and time made to the administrator on 08/04/22 at 4:24 p.m. On 07/29/22 at 12:15 p.m., an acceptable plan of removal was received as follow: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on July 28th, 2022 for Pressure Ulcer and Pain Action Item: All residents will have a skin assessment completed. All Residents with wounds will be assessed/reassessed and wound assessment documented as well as review of treatment orders resident specific. Physician is evaluating all residents pain management. All residents will be assessed/reassessed for pain and provided subsequent pain management per physician recommendations and will be provided resident specific treatment. Assess and review interventions. Staff will audit wound care treatments per shift for completion of treatment, pain assessment, interventions needed and physician notification as needed to address wounds and pain concerns. Person Responsible: Nursing Timeline for Compliance: 7/30/22 8:00pm CST Action Item: Resident #15 was sent to Emergency Department for Treatment and evaluation of wounds and pain. A low air loss mattress will be in place upon his return and to any resident that has been identified as needing a low air / treatment specific mattress. Note of noncompliance: Resident is non compliant with diabetic treatment; resident is non-compliant with Hemodialysis. Person Responsible: Nursing Timeline for compliance: 7/29/22 5:00pm CST (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: All Nurses will receive an in-service on pressure ulcers, interventions, assessments, and treatments. All direct care staff will be in-serviced on pain recognition, policy and procedures related to pain recognition, assessment, and appropriate intervention. Wound Treatment Nurse will be educated on how to assess for pain and proper interventions of a resident experiencing pain during wound treatments by the Corporate Resource Nurse. Person Responsible: Corporate Resource Nurse/DON Timeline for Compliance: 7/30/22 8:00pm CST Based on record review, observation, and interview, the facility failed to ensure pain management during pressure wound treatments for one (#15) of one resident observed during pressure wound treatment. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 11 residents with pressure ulcers. Findings: A policy titled, Wound Care, revised June 2022, read in part, .For example, the resident may have PRN order for pain medication to be administered prior to wound care . A policy title, Pain Assessment and Management, revised July 2022, read in parts, .The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain .Pain management is a multidisciplinary care process .Assessing the potential for pain; Recognizing the presence of pain; Identifying the characteristics of pain; Addressing the underlying causes of the pain . Resident #15 was admitted to the facility with diagnoses that included chronic osteomyelitis, pain, and pressure ulcers. Resident #15's Care Plan, revised 04/21/22, documented a category for pain with interventions to administer pain meds as ordered, establish causative factors and ways to alleviate them, and monitor pain. The care plan did not address pain associated with pressure ulcers and treatment. A Physician's Order, dated 06/19/22, documented to perform a wound treatment pain evaluation once a day on the first shift. A Physician's Order, dated 07/27/22, documented to give one tablet of hydrocodone/acetaminophen 7.5/325 mg every six hours routinely. This order had previously been PRN. No documentation was in the clinical record to indicate a reason for the change to routine. Resident #15's physician orders did not have any orders for break through pain such as PRN pain medication. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #15's TAR, dated July 2022, documented to monitor pain during wound treatment once a day. The TAR documented out of ten opportunities, three were blank, five were documented as zero pain, two were documented as not administered with reasons as other and drug/item unavailable. On 07/28/22 at 12:28 p.m., the wound nurse was observed to prepare wound treatments for resident #15's six pressure ulcer wounds. The nurse obtained supplies from the cart and entered the resident room. On 07/28/22 at 12:31 p.m., the wound nurse informed resident #15 the wound treatment was to be done. At no point prior to beginning the treatment did the wound nurse assess resident #15's pain. On 07/28/22 at 12:41 p.m., during the wound treatment of the resident's six wounds, the resident called out in pain, Oh, ow! multiple times as the wound nurse was cleaning out the deep wounds with gauze, and scooping out bloody drainage from the wounds. Resident #15 cried out again in pain when the wound nurse packed gauze with Santyl to the wound bed. After the wound was dressed, the wound nurse, on the side of the bed closest to the wall, and the CNA turned resident #15 toward the wall. Resident #15 yelled out, This hurts me! The nurse replied to the resident, I know it hurts, I'll let the nurse know when we leave here to try and get you some pain medicine. The resident was grabbing the sheet and pad with his right hand making a fist and yelled out, I had cake yesterday. The statement was in response to a question asked earlier by the CNA assisting the wound nurse. The wound nurse continued the treatment to resident #15's multiple wounds until completed. At 1:31 p.m., when the wound nurse had completed the treatments to resident #15's wounds, and was outside of the resident's room, the wound nurse was asked when the resident's pain would be addressed. The wound nurse stated they try to let the nurse and CMA know but because, You wanted to see him, we did it first. The wound nurse added, I should have let the nurses down here know. On 07/28/22 at 2:32 p.m., CMA #5 was asked what time resident #15 received pain medication. The CMA stated about a half hour after the wound treatment. The CMA stated the resident was in real bad pain, he kept saying, I'm in pain. The CMA was asked if the nurse had ever asked before the wound treatment to treat the resident's pain. They stated no. CMA #5 was asked why the pain medication was given if the medication had not been requested by the wound nurse. The CMA stated it was scheduled to be given. On 07/28/22 at 2:38 p.m., LPN #5 was asked if the wound nurse communicated with them about resident #15's pain. They stated no. LPN #5 was asked how the resident's pain was. They stated the pain medication had been changed to routine and the management of resident #15's pain had improved. The LPN was asked if the pain medication was effective. They stated it was a little better since the medication was made routine. The LPN was asked what the protocol was if a resident had pain during wound treatment. LPN #5 stated we should call the doctor and get them something. On 07/28/22 at 4:06 p.m., LPN #5 was asked why they had documented Resident #15's pain as a zero on the TAR for the wound treatment. They stated they had documented prior to the dressing change. No other explanation was provided. On 07/28/22 at 5:35 p.m., resident #15 was asked to rate their pain during the wound treatment. The resident stated a 10 on a zero to 10 scale. (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/29/22 at 2:57 p.m., CNA #4 was asked if they had assisted with Resident #15's wound treatments before 07/28/22. They stated no. The CNA was asked if the resident had complained of pain prior to the wound treatment. They stated yes, Resident #15 had and was treated with pain medication at 12:30 p.m., prior to the wound treatment. CNA #4 was asked if the drainage from the wound was typical. They stated it was a lot and stated they did not know when the dressing had been changed previously. On 08/04/22 at 5:56 p.m., the DON was asked what their expectations were of pain management during wound treatments. The DON stated to manage the pain and document. The DON was asked what if the resident did not have a PRN pain medication. The DON stated to call the doctor and get an order.

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	375568	A. Building B. Wing	08/04/2022

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41809 Based on record review and interview the facility failed to ensure sufficient staffing to meet the needs of the residents regarding medical social services, bathing, medication management, and wound management. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 96 residents resided at the facility. Findings: On 07/21/22 at 3:16 p.m., this surveyor was invited to the resident council meeting. During the meeting several residents brought up a concern regarding the lack of staff, call lights not getting answered, and transportation to appointments. Example 1 refer to F755 On 07/26/22 at 10:19 a.m., resident #10 stated they were not getting their medications as ordered, it was not until 9:30 to 10:30 at night when medications were received. Example 2 refer to F745. On 07/26/22 at 10:37 a.m., the medical records employee stated, Nobody is doing social services. We [themself and admissions personnel] are tag teaming social services. The medical records employee was asked how long the social services position was empty. They stated it had been a few months. On 07/26/22 at 3:53 p.m., the RRN was asked when the last time the social services position had been filled. They stated a social services employee started 07/19/22 and quit 07/20/22. The RRN was asked who had been working in that capacity since. They stated the corporate social worker had been in and out of the facility but had assumed the medical records employee was helping, other than that they did not know. Example 3 refer to F677 On 07/27/22 at 10:49 a.m., resident #4 who lived on north hall, was asked if they had concerns regarding the number of staff on their hall. They stated yes today they did not see a CNA on the hall until 9:30 a.m., another one came in right after. Resident #4 stated it did not make them feel safe. They expressed concern for the other residents on the hall who are not able to self advocate. On 07/27/22 at 10:56 a.m., CNA #12 stated they usually work the center hall on the 7:00 to 3:00 p.m. shift. They were asked what time they arrive to the north hall to work that day. They stated they arrived at 8:45 a.m. On 07/27/22 at 11:40 a.m., CNA #13 was asked what time they arrived to work that day. They stated 7:30 a. m. They stated they were working north hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/27/22 at 2:07 p.m., CNA #4 was asked if they were scheduled to work that day. They stated no that they had been called in to work on their day off. The CNA was asked who was at the facility when they arrived. They stated a nurse, the admissions person(office personnel), and the HR(office personnel) person. CNA #4 was asked what time they had arrived. They stated between 8:30 and 8:45 a.m. The facility's Midnight Census Report, documented 40 residents on the center hall, 19 residents on the north hall, and 34 residents on the southeast hall. On 07/29/22 at 1:18 p.m., CNA #6 was asked if the facility had enough staff to meet the needs of residents. The CNA stated no. CNA #6 was asked what did not get done. They stated showers. On 07/29/22 at 2:00 p.m., CNA #11 was asked if the facility had enough staff to meet the needs of the residents. The CNA stated no. CNA #11 was asked what did not get done. They stated cleaning resident rooms, changing resident linen, and showers. On 08/03/22 at 5:35 p.m., Resident #4 was asked if there was adequate staff to meet their needs. They stated, No. They stated, Bed baths and hair washing is hard to get done. Example 4 refer to F686 On 08/04/22 at 5:14 p.m., the DON was asked how staffing was determined. They stated it should be based on staffing ratios. The DON stated the facility put someone over staffing and they have contracted with outside staffing agencies.

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 07/26/22 at 5:31 p.m. an Immediate Jeopardy situation was identified and verified through the Oklahoma State Department of Health (OSDH) regarding neglect of the facility to ensure medical social services for Resident #10. Resident #10 presented to the facility a request from his cancer specialist, for a dental evaluation for clearance to begin chemotherapy and radiation to prevent the spread of cancer, on admission and two follow up visits on 04/05/22 and 07/18/22. The requests were unfulfilled by the facility. Resident #10 went five months without the requested dental evaluation. This neglect prevented Resident #10 from beginning his chemotherapy and radiation treatment and put the resident at increased risk for the spread of cancer. An acceptable Plan of Removal (POR) was submitted on 07/27/22 at 10:53 a.m. with notification made to the Administrator at 10:54 a.m. The POR was provided as follows: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on July 26th, 2022, for neglect and Medical social needs. Action Item: All residents will be reviewed for medical social services's needs. Interviews with the residents/responsibility[sic] party to assess for immediate medical social service's[sic] needs. Record review will be completed within 48 hours to assess medical social service needs. Person Responsible: Nursing and administration Timeline for completion: 7/27/22 by 1600 cst Action Item: Resident number ten will be scheduled for a follow up dental appointment for clearance related to chemotherapy. Person Responsible: Nursing and Administration scheduled his dental appointment for 8/23/22. The center is continuing to try to schedule an appointment sooner. The center will notify the Oncologist that the dental appointment has been scheduled and the the center continues to try to schedule an earlier appointment. Timeline for completion: 7/27/22 by 1600 cst Action Item: Medical Social Services will be monitored by Nursing and Administration until a Director of Social Services is in place. Monitoring will consist of the nurse managers reviewing all appointment follow up paperwork. Appointments will be made and transported by the transportation position. The Administrator and the nursing administration will review the completion of the process. Person Responsible: Administration/DON/Regional Nurse Manager Timeline for completion: 7/27/22 by 1600 cst (continued on next page)

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	375568	A. Building B. Wing	08/04/2022

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: The Administrator/DON/ Corporate resource social worker will re- inservice all staff on appointment process, follow up services required, neglect and documentation/notification of these services. Person Responsible: Administrator/DON/ Corporate resource social worker Timeline for completion: 7/27/22 by 1600 cst On 07/27/22 at 5:21 p.m., the immediacy was lifted upon the scheduling of Resident #10's dental appointment and in-services/education for staff, on meeting the social services needs of the residents, leaving the deficient practice at a level of isolated harm. Based on record review, observation, and interview, the facility failed to ensure medical social services scheduled and followed through with an appointment for clearance to receive chemotherapy/radiation for one (#10) of three residents reviewed for medical social services. The Resident Census and Conditions of Residents form, documented 96 residents reside at the facility. Findings: Resident #10 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of right kidney, Leukemia, and cutaneous squamous cell carcinoma of right ear (skin cancer). A Progress Note, dated 02/22/22, documented social services had left messages with the Indian clinic and the cancer specialist office regarding authorization for radiation treatment with no response. The note documented resident #10's case worker informed the [NAME] had done an authorization, and another message was left for the cancer specialist. No follow up was documented in the clinical record. A Progress Note, dated 03/22/22, read in part, .No outside referrals needed at this time. The note was signed by social services. No other notes were documented by social services. An Oklahoma Cancer Specialists and Research Institute document titled, Established Patient History and Physical, dated 04/05/22, documented resident #10 was seen by their cancer specialist. It read in parts, .He has not yet undergone his dental evaluation .Dental evaluation ASAP . This request was unfulfilled by the facility. On 07/18/22 resident #10 was seen by their cancer specialist who had requested a dental evaluation, a third time. This request was again unfulfilled by the facility. On 07/20/22 at 10:05 a.m., resident #10 stated they were first diagnosed with cancer three years ago. The resident stated they had not been to the dentist to be cleared for chemotherapy and radiation. Resident #10 stated they had surgery to remove the skin cancer near their right ear prior to entering the facility and was to be cleared for treatment by a dentist. The resident stated their chemotherapy/radiation was scheduled to begin in April 2022. The resident stated four appointments had been scheduled and canceled by his representative because the facility did not have transportation to get them to the dentist. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/21/22 at 10:11 a.m., resident #10's representative stated the number of dental appointments that had been scheduled and canceled were three. The representative stated they were surprised Resident #10 was able to get to the cancer specialist appointment on 07/18/22. They stated the facility told them they did not have transportation. The clinical record did not indicate Resident #18 had been to an appointment on 07/18/22. No documentation was found in the clinical record that indicated conversations with the representative or the resident. No documentation was found in the clinical record that attempts had been made to utilize outside resources for transportation of the resident to the dentist. On 07/21/22 at 10:33 a.m., LPN #3 was asked if Resident #10 had been to an appointment recently. They stated resident #10 had been to the cancer specialist on the 18th. They stated they only knew because the resident had informed them of the visit. The LPN stated residents should be signed out when leaving the facility. The LPN checked the sign out book, but resident #10 was not signed out that day. LPN #1 referred to the nurse that worked the 18th. On 07/21/22 at 10:45 a.m., LPN #4 stated they had worked resident #10's hall the 18th, but did not remember if the resident went out of the facility. The LPN stated the resident would have been signed out by transportation. The LPN stated the transportation person was new and may not have signed out the resident because it was their first day. On 07/21/22 at 11:00 a.m., the medical records person confirmed resident #10 was taken to an appointment on the 18th. They stated the nurse was to enter a progress note. MR was asked if Resident #10 brought back any record of the appointment. They stated yes but they had not scanned it into the system yet. On 07/26/22 at 10:37 a.m., MR stated the facility had no social services staff. They stated themselves and the HR person had been tag teaming social services for the past several months since there was no social services person. The MR staff person was asked if they were aware resident #10 had a follow up appointment in a month with their cancer specialist. They stated no, after they scanned in the paperwork it was given to the nurse who was to notify of any appointments or follow ups and chart on it. This was neglected to be completed. On 07/26/21 at 12:31 p.m., Resident #10's cancer specialist stated resident #10's care and treatment had been compromised due to not getting his treatments for cancer post surgery. The doctor stated it had been four months since a dental clearance was requested. The doctor stated the skin cancer had been removed but without chemotherapy/radiation it could come back. The doctor stated they like to do treatments within one to two months after surgery. The doctor stated the neglect of the facility to ensure Resident #10 was cleared by a dentist for chemotherapy/radiation delayed the treatment and put Resident #10 at risk for the cancer to return and spread. On 07/26/22 at 3:53 p.m., the RRN #2 was asked how long social services had been empty. They stated one had been hired, but only worked one day and quit last Wednesday. They stated the corporate social worker had been in and out of the facility. The RRN was asked who assistedwith social services when the corporate social worker was not present. They stated, I'm assuming MR was helping. Other than than I don't know. The RRN was asked who documented or scheduled follow up appointments. They stated the nurse should document on the resident's calendar. The RRN was asked if their system worked. They stated, We know it's broken.

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	375568	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191 Based on record review and interview, the facility failed to ensure medications were administered per physicians' orders for four (#2, 8, 9, and #10) of four sampled residents reviewed for medications. The Resident Census and Conditions of Residents report, dated 07/20/22, documented 96 residents resided in the facility. Findings: A facility policy for Medication Orders and Receipt Record, dated 04/2007, read in parts, .The Director of Nursing Services will designate individuals to be responsible for completing medication order/receipt forms . Medications should be ordered in advance, based on the dispensing pharmacy's lead time . A Medication Administration policy, dated 01/2021, read in part, .Medications are administered as prescribed .Medications are administered in accordance with written orders from the prescriber .The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given . 1. Resident #2 had diagnoses of chronic pain, end stage renal disease, heart failure, recurrent major depressive disorder, artherosclerotic heart disease, and anxiety disorder. A physician's order, dated 12/08/21, documented to administer Clopidogrel (A medication used to prevent heart attacks and strokes in persons with heart disease or blood circulation disease.) 75 mg daily. A physician's order, dated 02/09/22, documented to administer melatonin 5 mg at bedtime. A physician's order, dated 02/19/22, documented to administer cyproheptadine 4 mg at bedtime. A physician's order, dated 05/25/22, documented to administer Xanax 0.5 mg every morning and 1 mg at bedtime for anxiety disorder. A physician's order, dated 06/20/22, documented to administer Neurontin 300 mg one capsule. A physician's order, dated 07/11/22, documented to administer Cymbalta 60 mg twice a day for pain/anxiety. A physician's order, dated 07/13/22, documented to administer Oxycodone 10 mg every six hours as needed for pain. The medication administration record, dated 07/2022, documented the following medications were not administered as ordered due to the medications not being available: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Clopidogrel 75 mg had not been administered five out of 31 opportunities; b. melatonin 5 mg had not been administered four out of 31 opportunities; c. cyproheptadine 4 mg had not been administered seven out of 31 opportunities; d. Neurontin 300 mg had not been administered six out of 31 opportunities; e. Cymbalta 60 mg had not been administered two out of 15 opportunities; and f. Oxycodone 10 mg had not been administered four out of 24 opportunities. The medication administration record, dated 08/01/22 through 08/04/22, documented the following medications were not administered due to the medication being unavailable: a. melatonin 5 mg had not been administered three out of three opportunities; b. Xanax 0.5 mg had not been administered two out of four opportunities; and c. Xanax 1 mg had not been administered one out of three opportunities. A controlled drug record for Xanax 0.5 mg tablets, dated 07/02/22 through 08/02/22, documented Xanax 0.5 mg two tablets were administered on 08/02/22 at 7:33 p.m., and documented no remaining doses of medication were available for administration. A controlled drug record for Oxycodone IR 10 mg tablets, dated 07/15/22 through 08/04/22, documented Oxycodone IR 10 mg one tablet was administered on 08/04/22 at 12:36 a.m. and documented no remaining doses were available for administration. A Refill Order Form, dated 08/04/22, documented a reorder request for Xanax and Oxycodone had been sent to the pharmacy. On 08/04/22 at 9:12 a.m., Resident #2 stated they did not get their medications at times because the facility ran out of the medication. Resident #2 was asked how often the facility ran out of their pain medication. Resident #2 stated it happened four times in the last three months. Resident #2 stated they were in pain and requested the Oxycodone immediate release. Resident #2 stated the facility was currently out of their Oxycodone IR tablets and their Xanax. On 08/04/22 at 9:28 a.m., the medication inventory for resident #2 was reviewed with LVN #2. The medication cart was observed and did not have Xanax 0.5 mg or Oxycodone IR (immediate release) 10 mg tablets available for administration. LVN #2 stated they had called the pharmacy multiple times and the phone rang but nobody answered. LVN #2 stated they had faxed a request for refill of the Xanax and the Oxycodone IR on 08/04/22. LVN #2 was asked about the process for reordering medication. The LVN stated there was a reorder button in the computer medication charting system to reorder the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN #2 stated the CMA could reorder the non controlled medications. LVN #2 stated they were not sure who was responsible for ordering the controlled medications. On 08/04/22 at 10:08 a.m., the RRN was asked about the facility's policy for reordering medication. The RRN stated they did not know the facility's policy but would expect there to be a seven day supply of the residents' medication in the building. The RRN was asked about the missing medications on the July and August medication administration record. The RRN stated according to the documentation the medications were not administered due to them not being available. The RRN observed the medication cart and controlled inventory records. The RRN stated the medications were not available for administration. The RRN stated Resident #22 had two doctors who had prescribed pain medication and that could have been the reason the pain medication had not been refilled. 35749 2. Resident #8 had diagnoses which included end stage renal disease, diabetes mellitus, constipation, neuropathy, GERD, UTI, and pain. Physician's orders, dated 03/30/22, documented to administer the following: a. ascorbic acid 500 mg twice daily, b. Clopidogrel 75 mg daily, c. cyanocobalamin 100 mcg daily, d. Eliquis 5 mg daily, e. furosemide 20 mg daily, f. oxybutynin 5 mg daily, and g. Senna plus 8.6-50 mg twice daily. A Physician's Order, dated 04/01/22, documented to administer Percocet 7.5/325 mg every six hours. A Physician's Order, dated 04/20/22, documented to administer midodrine 10 mg three times daily. A Physician's Order, dated 04/22/22, documented to administer Retacrit 10,000 u three times weekly on Monday, Wednesday, and Friday. The April 2022 MARs documented the following: a. retacrit had not been administered three out of four opportunities, b. senna had not been administered six out of 43 opportunities, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Clopidogrel had not been administered two out of 22 opportunities, d. cyanocobalamin had not been administered two out of 22 opportunities, e. gabapentin had not been administered two out of 43 opportunities, f. Eliquis had not been administered six out of 43 opportunities, and g. midodrine had not been administered three out of 32 opportunities. Physician's Orders, dated 05/20/22, documented to administer the following: a. oxybutynin 5 mg daily, and b. pantoprazole 40 mg daily. The May 2022 MARs documented the following: a. retacrit had not been administered 11 out of 13 opportunities, b. Lantus had not been administered two out of 31 opportunities, c. ascorbic acid had not been administered 16 out of 62 opportunities, d. aspirin had not been administered four out of 31 opportunities, e. Atorvastatin had not been administered 15 out of 31 opportunities, f. Clopidogrel had not been administered five out of 31 opportunities, g. Eliquis had not been administered 11 out of 62 opportunities, h. gabapentin had not been administered eight out of 62 opportunities, i. midodrine had not been administered eight out of ninety three opportunities, j. miralax had not been administered five out of 31 opportunities, k. oxybutynin had not been administered five out of 20 opportunities, l. pantoprazole had not been administered six out of 31 opportunities, m. Percocet had not been administered 17 out of 124 opportunities, and n. senna had not been administered five out of 62 opportunities. A Physician's Order, dated 06/08/22, documented to administer Miralax 17 gms daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The June 2022 MARs documented the following: a. Lantus had not been administered one out of 30 opportunities, b. ascorbic acid had not been administered two out of 60 opportunities, c. aspirin had not been administered two out of 30 opportunities, d.atorvastatin had not been administered one out of 30 opportunities, e. Clopidogrel had not been administered one out of 30 opportunities, f. cyanocobalamin had not been administered four out of 30 opportunities, g. Eliquis had not been administered two out of 30 opportunities, h. gabapentin had not been administered two out of 46 opportunities, i. midodrine had not been administered seven out of 90 opportunities, j. miralax had not been administered one out of 30 opportunities, k. gabapentin (page 15 missing) l. oxybutynin had not been administered two out of 30 opportunities, m. Percocet had not been administered 12 out of 120 opportunities, n. retacrit had not been administered seven out of 10 opportunities, and o. senna had not been administered two out of 60 opportunities. A Physician's Orders, dated 07/03/22, documented to administer cyclobenzaprine 10 mg twice daily and Prozac 10 mg daily. The July 2022 MARs documented the following: a. Lantus had not been administered six out of 17 opportunities, b. ascorbic acid had not been administered four out of 28 opportunities, c. Atorvastatin had not been administered two out of 21 opportunities, d. cyclobenzaprine had not been administered two of 14 opportunities, d. Eliquis had not been administered three out of 24 opportunities, e. midodrine had not been administered three out of 58 opportunities, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. gabapentin had not been administered three out of 40 opportunities, g. oxybutynin had not been administered one out of 22 opportunities, h. pantoprazole had not been administered one out of 16 opportunities, and i. Prozac had not been administered two out of 18 opportunities. Missed opportunity reasons/comments for April, May, June, and July documented medication unavailable, resident unavailable (in dialysis), sleeping. pending pharmacy delivery, or the administration was blank. On 08/03/22 at 3:50 p.m., CNA #14 was asked what the policy was for administering medications. They stated they would check the MARs and the doctors orders. They were asked how staff documented medication administration. They stated by the initials on the MAR. They were asked what a blank on the MAR indicated. They stated if it was blank, the medication wasn't given. They were asked how they re-ordered medications. They stated they re-order in the computer. On 08/03/22 at 4:11 p.m., LVN #8 was asked for the policy for administering medications. They stated they follow rights and physician orders. They were asked how staff documented medications had ben given. They stated on the emar. They were asked what blanks on the MAR indicated. They stated they would check with the previous shift to see if they had given the medication and stated, It could literally not been given at all. They were asked how medications were administered to dialysis residents. They stated they had orders to work around dialysis. On 08/03/22 at 4:35 p.m., Resident #8 was asked if they received their medications as ordered. They stated, Pretty well. They were asked if the facility had ever run out of their medications. They stated, I don't know. They were asked when they receive their medications on dialysis days. They stated, Sometimes before, sometimes after. On 08/03/22 at 4:47 p.m., the corporate nurse was asked about the policy for administering medications. They stated to following the doctors orders and document in the emar. They were asked what it indicated if there were blanks on the MARs. They stated, I'd assume it wasn't given. They were shown the above MARS. They stated some of the medications marked unavailable were OTC or available in the emergency pharmacy kit. They stated pharmacy delivered up to three times a day. They stated staff should have modified the medications around dialysis. The corporate nurse was asked to review Resident #8's narcotic count sheet to determine if the Percocet had been administered. They stated, The narc sheet doesn't tell me you gave it, the MAR does. 3. Resident #9 admitted on [DATE] with diagnoses which included ESRD, DM with neuopathy, CHF, hyperlipidemia, asthma, and atrial fibrillation. Physician's Orders, dated 06/20/22, documented the following: a. insulin aspart per ss before meal and at bedtime, b. clopidegrel 75 mg daily, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Lyrica 75 mg at bedtime, d. atorvastatin 20 mg at bedtime, and e. sevelar carbonate 800 mg with meals. Physician's Orders, dated 06/29/22, documented to administer insulin aspart ss before meals and at bedtime and symbicort inhaler two puffs twice daily. A Physician's Order, dated 06/30/22, documented to administer Coreg 3.125 mg twice daily. The June 2022 MARs documented the following: a. insulin aspart had not been administered four out of 34 opportunities, b. clopidegrol had not been administered one out of ten opportunities, and c. Lyrica had not been administered 11 out of 11 opportunities. The July 2022 MARs documented the following: a. atorvastatin had not been adminstered two out of 10 opportuinities, b. insulin aspart had not been administered (look at page 5 for results) c. Coreg had not been administered three out of 20 opportunities, d. Lyrica had not been administered ten out of ten opportunities, e. sevalamer carbonate had not been administered two out of 31 opportunities, and f. Symbicort had not been administered eight out of 20 opportunities. A Pharmacy Order Status sheet, dated 06/01/22 through 08/04/22 contained no documentation the Lyrica had been ordered. On 08/04/22 at 10:00 a.m., the corporate nurse was shown the above MARs. She acknowledged the medications had not been administered as ordered. 41809 Resident #10 was admitted to the facility with diagnoses that included diabetes type two and cardiopmyopathy. A Physician's Order, dated 01/31/22, documented to give atorvastatin 80 mg one tab daily. A Physician's Order, dated 01/31/22 to 07/17/22, documented to give carvedilol 3.125 mg twice a day, hold if pulse less than 60. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 01/31/22, documented to give one spray in each nostril of fluticasone propionate 50 mcg/actuation once daily. A Physician's Order, dated 01/31/22 to 07/17/22, documented to give one tab of Ranexa 500 mg every 12 hours. Resident #10's MAR, dated July 2022, documented the medication atorvastatin was unavailable to administer four times out of 28 opportunities. One time the medication was documented as refused. Two times the medication administration was blank. The medication carvedilol was documented to not be given four out of 17 opportunities, with one date documented as refused. The other three were left blank. The medication fluticasone propinonate was documented as not given three out of 28 opportunities with one documented as refused. On 07/26/22 at 10:19 a.m., resident #10 stated they were not getting their medications as ordered, it was not until 9:30 to 10:30 at night when medications were received. On 08/03/22 at 3:50 p.m., CNA #14 was asked what the policy was for administering medications. They stated they would check the MARs and the doctors orders. They were asked how staff documented medication administration. They stated by the initials on the MAR. They were asked what a blank on the MAR indicated. They stated if it was blank, the medication wasn't given. They were asked how they re-ordered medications. They stated they re-order in the computer. On 08/03/22 at 4:11 p.m., LVN #8 was asked for the policy for administering medications. They stated they follow rights and physician orders. They were asked how staff documented medications had ben given. They stated on the emar. They were asked what blanks on the MAR indicated. They stated they would check with the previous shift to see if they had given the medication and stated, It could literally not been given at all. They were asked how medications were administered to dialysis residents. They stated they had orders to work around dialysis. On 08/03/22 at 4:47 p.m., the corporate nurse was asked about the policy for administering medications. They stated to following the doctors orders and document in the emar. They were asked what it indicated if there were blanks on the MARs. They stated, I'd assume it wasn't given.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 36191 Based on record review, observation, and interview the facility failed to ensure food was served at a palatable temperature for one (evening meal) of one meal observed for palatable temperature. The DON identified 89 residents received meals from the kitchen. Findings: The following concerns related to cold food were identified during resident council meetings: Resident council meeting minutes, dated 03/09/22, read in parts, .Cold food in dinning [sic] room .Residents are concern [sic] about food getting worse . Resident council meeting minutes, dated 06/07/22, read in parts, .Cold food Concern .Admin shared new equipment has been ordered . A grievance form, dated 06/23/22, read in parts, .Cold food. If not passed while hot will be cold .Resolution . Hot plates in use starting today completely .Plates have to past [sic] in timely manner or hot plates will be cold .06/24/22 . On 07/20/22 at 9:14 a.m., resident #25 stated they always get a tray and it is not always hot. They stated the issue had been brought up in resident council multiple times but the concern never seemed to get addressed. On 07/20/22 at 1:06 p.m., staff were observed to bring the afternoon meal to the southeast hall from the service hall behind the kitchen. Resident plates were on a two level push cart. The plates were observed to be uncovered on the cart. When each plate was served, the empty cart was taken back down the service hall to the kitchen where staff waited for another cart for their hall. On 07/20/22 at 1:24 p.m., resident #10 was observed to receive an afternoon meal. The surveyor followed the staff in and asked the resident if the food that was received was hot. The resident touched the food on their plate and stated the food was cold. Resident council meeting minutes, dated 07/21/22, read in part, .food is cold . On 08/03/22 at 5:02 p.m., Resident #19 was asked if the warm food was served at a warm temperature. Resident #19 stated at times the food was cold. On 08/03/22 at 5:11 p.m., Resident #21 was asked if the warm food was served warm. Resident #21 stated it was cold most of the time. On 08/03/22 at 5:25 p.m., Resident #24 was asked about the food. Resident #24 stated they ate in their room most of the time and the food was at times served late and was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/03/22 at 5:47 p.m., CNA #1 was asked if the residents complained about their food being served cold. CNA #1 stated, Yes. On 08/03/22 at 5:50 p.m.,, the survey team was provided the last tray after the last resident had been served from that meal cart. The french toast had a temperature of 88.2 degrees Fahrenheit (F), the ham was 88.7 degrees F, and the fried potatoes were 89.7 degrees F. The french toast, ham and fried potatoes were cold to touch. On 08/03/22 at 6:04 p.m., the dietary manager was made aware of the observations of the cold food and the temperatures. The dietary manager stated they had purchased a plate warmer and the staff was inserviced on 08/03/22 on how to use the plate warmer. The dietary manager was asked for the holding temperatures of the evening meal. They stated the food was not held before it was plated. No holding temperatures were documented. On 08/03/22 at 6:07 p.m., Resident #21 stated they had french toast, ham, and fried potatoes for dinner. Resident #21 stated it had been cold at the time it was served. 41809

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41809 Based on record review, observation, and interview, the facility failed to ensure infection control was followed during pressure wound treatments for one (#15) of one resident observed during pressure wound treatments. The Resident Census and Conditions of Residents form, dated 07/20/22, documented 11 residents with pressure wounds resided at the facility. Findings: A facility policy titled, Wound Care, revised June 2022, read in parts, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Verify that there is a physician's order for this procedure .Put on clean gloves .Loosen tape and remove dressing .Pull glove over dressing and discard into appropriate receptacle. Perform hand hygiene .Put on clean gloves .Wash wound in a circular motion from the inside out with ordered wound cleanse. Use additional gauze and repeat as needed with fresh gauze each time . On 07/28/22 at 12:28 p.m., the wound nurse was observed during pressure wound treatments for resident #15's six pressure ulcers. Upon removal of the dressings the dates of the removed dressings were observed to be 07/26/22. The wound nurse was observed to not clean the wounds in an aseptic manner. The nurse cleaned the heel quickly in continuous circles with gauze. The left lateral shin wound was cleaned with gauze moving quickly and continuously from left to right and right to left. The wound nurse was not observed to change gloves between removing a dirty dressing, cleaning the wounds, or applying a new dressing. The dressing to the resident's sacrum was observed to be saturated and was observed to have a faded date of 07/26/22. On 07/28/22 at 1301, the certified wound nurse was asked if the treatments were completed. They stated yes. The nurse was asked to step out into the hall. The nurse was asked when a glove change was indicated. The certified wound nurse stated their training indicated after cleaning feces or urine, and to remove gloves when leaving the room and don new gloves when re-entering the room. The certified wound nurse was asked if gloves were required to be changed after removing a dressing, before cleaning a wound, or applying a new dressing. The certified wound nurse stated their training did not teach that. On 08/04/22 at 5:56 p.m., the DON was asked what their expectations were of the wound nurse when performing wound treatments and infection control. The DON stated they expected the nurse to follow infection control protocol and physician orders.