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	10/04/2022

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure personal funds were conveyed within 30 days of death for one (#7) of two sampled residents who were reviewed for personal funds. The Admit/Discharge Report, dated [DATE] through [DATE], identified two residents who had expired and were in the trust account. Findings: Resident #7 had diagnoses which included chronic respiratory failure. The Admit/Discharge Report, dated [DATE] through [DATE], documented Resident #7 had expired on [DATE]. The Current Balance Report, dated [DATE], documented Resident #7 had $1,596.72 in the trust account. The Resident Ledger, dated [DATE] through [DATE], revealed the resident had a balance of $1,746.72 on [DATE]. A transaction, dated [DATE], documented the check number was to be determined in the amount of $150.00. The resident account balance as of [DATE] was documented as $1,596.72. On [DATE] at 4:47 p.m., the BOM was asked who was responsible to ensure funds were conveyed within 30 days of death. They stated the business office manager was responsible to request a refund from corporate within five days and the funds were then released to the appropriate party. The BOM was asked why the funds for Resident #7 had not been conveyed within 30 days of death. They stated they became the BOM three weeks ago and the corporate BOM was the interim BOM for the facility prior to their starting. The BOM was asked how much money was to be conveyed for Resident #7. They stated the $150.00 was for dental services but would not be submitted. The BOM stated the resident's ending balance to be conveyed was $1, 746.72. On [DATE] at 1:04 p.m., the Regional Account Manager was asked why Resident #7's funds had not been conveyed within 30 days of death. They stated they would need to check into the issue. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:16 p.m., the Regional Account Manager stated the resident had expired during a transition between staff in the business office. They stated the conveyance of personal funds had slipped through the cracks. 41809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation and interview, the facility failed to ensure residents were provided with a clean and sanitary homelike environment. The Resident Census and Conditions of Residents form identified 100 residents lived in the facility. Findings: An undated Carpet Schedule documented floor cleaner/deodorizer was used daily and a triple action spot treatment was used on stained areas. The cleaning schedule documented each hall was scheduled to be cleaned weekly. On 09/12/22 at 1:48 p.m., the carpet on the center hall was observed to have dark track marks from the beginning of the hall to the end of the hall. In room [ROOM NUMBER] the baseboard was partially falling off inside the resident room. On 09/12/22 at 2:13 p.m., the hall between the southeast and the kitchen access halls, that housed the medical records office and activities office, had dark track marks going the length of the hall. The carpet on the southeast hall was stained in multiple areas. On 09/12/22 at 2:29 p.m., the southeast hall had an odor of urine. The odor was not able to be located to a specific location or room. On 09/12/22 at 2:31 p.m., the center hall leading to north hall was observed to have stained carpet with dark tracks down the entire length of the hall. The north hall was observed to have stained carpet in multiple areas. On 09/13/22 at 8:40 a.m., a urine odor on the southeast hall was outside of rooms [ROOM NUMBER]. room [ROOM NUMBER] was observed to be located directly across the hall from rooms [ROOM NUMBERS]. On 09/13/22 at 4:33 p.m., the southeast hall carpet was observed to have multiple stains and dark tracks that ran the entire length of the hall. On 09/22/22 at 11:15 a.m., the housekeeping supervisor was asked how often the carpets were cleaned. They stated daily with hot water and a spot cleaner. They were asked if it was effective. They stated some areas of the carpet were more stained than other areas. The housekeeping supervisor was asked why the carpets were still stained if they were cleaned daily. They stated if the stains were deep they would keep coming back. On 09/22/22 at 11:32 a.m., the administrator was asked why the carpets throughout the facility were stained and discolored. They stated the housekeepers cleaned daily but the carpet was old. The administrator stated that they did not know that anything they had tried was effective. They stated they were going to rip the carpet up next week. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/22/22 at 12:10 p.m., the housekeeping supervisor returned and stated they cleaned the carpets on a schedule and used a stain spot treatment. They were asked if the interventions were effective to maintain the carpet. They stated it helped in some areas, but some areas had been neglected for so long it was not effective. The housekeeping supervisor was asked how they maintained a homelike environment regarding the odors. They stated they used a deodorizer for the odors but it only helped for half a day.

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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** 35474 On 09/28/22 at 9:38 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to prevent abuse for one (#1) when the facility failed to ensure Resident #1 was not humiliated when LPN #1 made fun of them and laughed at them in a demeaning and humiliating way. The nurse stated the statement made by Resident #1 to EMSA, regarding the nurse refusing to provide suction, was Bullshit, was laughing while walking out of the room, and began talking and laughing with other staff in the hallway regarding Resident #1's statements to EMSA. On 09/28/22 at 9:46 p.m., the facility's administrator, Regional Nurse Manager #1, the Chief Operating Officer, and the corporate Survey Focus Coordinator was made aware of the IJ situation related to the facility's failure to prevent abuse. A plan of removal of the IJ situation was requested. A plan of removal was received on 10/04/22 and accepted on 10/06/22. The facility was notified the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of isolated harm. The plan of removal documented: Plan of Removal F600 The facility failed to prevent abuse. Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 9/28/2022, for implementing the abuse policy. Action Item: The DON, the nurse and the C.N.A. were suspended on 9/28/22 pending investigation of incident. The DON than stated she was self-terminating. Person Responsible: Regional Nurse Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Education to all staff on the centers abuse prevention program, recognizing signs and symptoms of abuse/neglect, abuse reporting timely, abuse investigation and neglect policies; resident rights and SLP Compliance Program with emphasis on Professional Conduct and all staff not present will be provided education to starting of next shift. All staff will complete abuse skills competency and posttest and or return demonstration, resident rights and grievance posttest and return demonstration before next shift. Person Responsible: Administrator/DON/ADON/Unit Manager/Regional Nurse Manager Completed on 10/4/22 5:00 pm Central Time (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: Review self-reports from previous 30 days to determine if the investigation has been completed thoroughly. No deficient practice was noted, all investigation were completed and reported to the Oklahoma Department of Health timely. Documentation of this review is in the POR binder. Person Responsible: Chief Operating Officer/Administrator/Regional Nurse Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Safe surveys will be completed via questionnaire with all residents that are interviewable; responsible parties will be phone interviewed for all residents that are not interviewable and those residents were interviewed for signs of physical or psychosocial distress and documented. Any allegations of abuse coming from the interviews were reported to the Oklahoma Department of Health. All allegations of abuse are reviewed in morning meeting and investigation initiated immediately upon notification with reportable submitted to the Oklahoma Department of Health. 1. Psychosocial harm was assessed through resident interviews for interviewable residents and residents that are not interviewable with families to evaluate and determine physical and emotional abuse. 2. Non-interviewable residents had skin assessments completed with no concerns of physical harm identified. Families were contacted for signs of psychosocial concerns, with none identified. 3. Staff re-education and monitoring will be completed routinely and as needed to prevent abuse and ensure proper reporting of all allegations. 4. Any revisions or changes will be addressed and reevaluated with findings addressed in QAPI meeting. Follow up reviews will be held by the Administrator and DON every Wednesday at 3:00pm CST with the Resident at Risk Team in the clinical management office. Regional Director of Operations will review Administrator and Don Resident of Risk Team findings for identified concerns and will address immediately and take to QAPI for further follow up. POR will tick and tie the audit tools to validate the POR has been completed and all allegations are investigated and reported timely. Person Responsible: Regional Nurse Manager/ ADON/DON/Unit Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Review of all nurses notes from prior 7-day period to identify any allegations of abuse that were not reported timely. Review of grievance log for the past 30 days. Three allegations were noted from the nurse note review. Zero allegations were noted from the grievance review. The Regional Nurse Manager reported the allegations from the nurse notes to the Administrator. The administrator self-reported the three allegations to the Oklahoma Department of Health on 9/28/22. Person Responsible: Regional Nurse Manager/DON/ADON/Unit Manager (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Completed on 10/4/22 5:00 pm Central Time Action Item: Ad hoc QAPI to review POR, and effectiveness with the IDT to include the medical director. Screening, Training, Prevention, Identification, Investigation, Protection and Reporting/response Person Responsible: Regional Nurse Manager/Regional Director of Operations/DON/ADON/Unit Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Regional Director of Operations/COO will review the POR to tick and tie the audit tools to validate the POR has been completed by 10/4/22. Person Responsible: Regional Director of Operations/Additional RDO/COO Completed on 10/4/22 5:00 pm Central Time Please accept our plan of removal and lift the jeopardy effective 10/4/2022 . Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for one (#1) of ten sampled residents who were reviewed for abuse. The Resident Census and Conditions of Residents form identified 100 residents resided in the facility. Findings: The Abuse Prevention Program policy, dated June 2021, read in parts, .Our residents have the right to be free from abuse .Our center will not condone any form of resident abuse . Resident #1 had diagnoses which included depression and tracheostomy status. An annual assessment, dated 08/17/22, documented the resident had a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making. The Employee Time Card, dated 09/16/22 through 09/30/22, documented LPN #1 worked from 09/24/22 through 09/27/22. The employee was not suspended until 09/29/22. On 09/27/22 at 4:30 p.m., Resident #1 stated on 09/24/22 they had called EMSA to suction them because the nurse had suctioned them and the resident felt it was ineffective. The resident stated while EMSA was present LPN #1 offered them a breathing treatment but the resident was not confident the nurse would return to remove the breathing treatment when it was completed because the nurse was unreliable. The resident stated the DON offered to stay and provide a breathing treatment and suction and LPN #1 left the room. Resident #1 stated EMSA was in the room and they heard LPN #1 laughing at and making fun of the resident when LPN #1 had left the room. The resident stated EMSA personnel #1 stated, They're out there making fun of him. Laughing at him. The resident stated they asked the DON if they were going to do anything about LPN #1 laughing at and making fun of them. Resident #1 stated the DON stated there was nothing they could do about it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/27/22 at 4:56 p.m., the DON was asked if they had provided any care to Resident #1 on 09/24/22. The DON stated they had provided a breathing treatment and suctioning while EMSA was present. The DON was asked if they overheard staff laughing at or making fun of Resident #1. The DON stated the resident told them the nurse was making fun of them and giggling at them. They were asked if they had reported the allegation. The DON stated they had not reported the allegation because they had only heard a conversation between EMSA personnel and the resident. The DON was asked if the resident had asked them to do something about the nurse laughing at and making fun of them. The DON stated LPN #1 was not an employee of the facility and worked for agency. The DON stated they had instructed the resident to report the allegation to the state surveyors on Monday. The DON stated, I left it at that because I didn't hear it myself. The DON was asked if they had received training regarding abuse. They stated they did not think so but maybe they did when they were hired. They were asked what the types of abuse were. They stated verbal, physical, and mental. The DON was asked if the resident's allegation of the nurse making fun of and laughing at him was an allegation which required further investigation. They stated they did not know because they had not witnessed the incident. The DON was asked if they had asked the resident or staff for further details regarding the allegation. They stated no. The DON stated they should have gotten a statement but they did not know what the facility's policy was. On 09/28/22 at 4:25 p.m., EMSA personnel #2 was asked about the run made on 09/24/22 for Resident #1. They stated they had gotten a call a resident with a tracheostomy needed suctioning. They stated when they arrived LPN #1 began defending themselves and as the nurse walked out of the resident's room the nurse began laughing at the resident and was heard in the hall laughing and talking to other staff about Resident #1. They stated LPN #1 was bashing the resident the whole time and was disrespectful to the resident. EMSA personnel #2 stated the resident was crying. EMSA personnel #2 was asked what they meant by bashing. They stated when they first arrived the staff were gathering to find out what was going on, laughing, and talking about the resident. They were asked what the LPN #1 said about the resident. EMSA personnel #2 stated the LPN #1 told the other staff the resident had said LPN #1 had refused to suction them and that was bullshit. They stated the nurse was repeating what the resident had said and mocked the resident. They stated another nurse (DON) had entered the room and heard Resident #1 talking to them about the allegation. EMSA personnel #2 stated they notified the nurse they were not okay with how LPN #1 had treated the resident. EMSA personnel #2 stated the nurse agreed with EMSA filing a report on the incident. On 09/28/22 at 6:22 p.m., LPN #1 was asked what had happened when EMSA came to the facility on [DATE] for Resident #1. LPN #1 stated they had suctioned the resident but they requested deeper suctioning. They stated they offered the resident a breathing treatment. The resident stated they wanted a second opinion and the DON discussed the breathing treatment with the resident and provided it. LPN #1 stated when EMSA arrived and entered the room, the resident had called LPN #1 a liar and was incompetent. LPN #1 stated they smirked and walked out of the resident's room, leaving the resident with the two EMSA personnel. LPN #1 was asked if they had laughed at or made fun of the resident. They stated they had only smirked. LPN #1 stated the DON had told them they were laughing at the resident. LPN #1 stated they told the DON they had just smirked. On 09/28/22 at 7:00 p.m., Resident #1 was asked how it made them feel when LPN #1 laughed at and made fun of them on 09/24/22. They stated they cried. They stated it made them feel like they did not matter and that their life and health was a joke. The resident stated, She kept it going throughout the days. They stated the other staff knew what happened and it was embarrassing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/29/22 at 1:58 p.m., the administrator stated during their investigation of the allegation involving Resident #1 the DON self-terminated when they were suspended, pending the investigation. They stated they suspended CNA #4 because they were involved in laughing and making fun of the resident. On 10/04/22 at 9:58 a.m., the administrator was asked how staff were made aware of the abuse protocol. They stated they provided inservices and also provided one on one education as needed. The administrator was asked how the facility protected residents from abuse. They stated if they received an allegation of abuse they immediately suspended the employee pending investigation. They were asked what the facility's policy was if a resident reported an allegation of abuse to a staff member. They stated they were to immediately report the allegation to them, the employee's supervisor, or the DON. The administrator was asked why the abuse policy was not implemented when the DON had received an allegation of abuse from Resident #1 on 09/24/22. They stated they did not know. The administrator stated they had asked the DON why they had not implemented the policy and the DON reported to them they had not heard the laughing at and making fun of the resident directly. 41809

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35474 On 09/28/22 at 9:38 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to implement their abuse policy for one (#1) when the DON failed to identify abuse when Resident #1 was humiliated when LPN #1 made fun of them and laughed at them in a demeaning and humiliating way. The nurse stated the statement made by Resident #1 to EMSA regarding the nurse refusing to provide suctioning was Bullshit, was laughing while walking out of the room, and began talking and laughing with other staff in the hallway, regarding Resident #1's statements to EMSA. On 09/28/22 at 9:46 p.m., the facility's administrator, Regional Nurse Manager #1, the Chief Operating Officer, and the corporate Survey Focus Coordinator was made aware of the IJ situation related to the facility's failure to implement the abuse policy. A plan of removal of the IJ situation was requested. A plan of removal was received on 10/04/22 and accepted on 10/06/22. The facility was notified the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of isolated harm. The plan of removal documented: Plan of Removal F607 The facility failed to implement their abuse policy. Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 9/28/2022, for implementing the abuse policy. Action Item: The DON, the nurse and the C.N.A. was suspended on 9/28/22 pending investigation of incident. The DON than stated she was self-terminating. Person Responsible: Regional Nurse Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Education to all staff on the centers abuse prevention program, recognizing signs and symptoms of abuse/neglect, abuse reporting timely, abuse investigation and neglect policies; resident rights and SLP Compliance Program with emphasis on Professional Conduct and all staff not present will be provided education to starting of next shift. All staff will complete abuse skills competency and posttest and or return demonstration, resident rights and grievance posttest and return demonstration before next shift. Person Responsible: Administrator/DON/ADON/Unit Manager/Regional Nurse Manager/Director of Clinical Practice Completed on 10/4/22 5:00 pm Central Time (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: Review self-reports from previous 30 days to determine if the investigation has been completed thoroughly. No deficient practice was noted, all investigation were completed and reported to the Oklahoma Department of Health timely. Documentation of this review is in the POR binder. Person Responsible: Chief Operating Officer/Administrator Completed on 10/4/22 5:00 pm Central Time Action Item: Safe surveys will be completed with all residents that are interviewable; responsible parties will be interviewed to determine if the responsible party believes the resident has suffered psychological harm, all residents that are un-interviewable will have a skin assessment to assess for physical harm. Person Responsible: Regional Nurse Manager/ADON/DON/Unit Manager Completed on 10/4/22 5:00 pm Central Time Action Item: Review of all nurses notes from prior 7-day period to identify any allegations of abuse that were not reported timely. Review of grievance log for the past 30 days. Three allegations were noted from the nurse note review. Zero allegations were noted from the grievance review. The Regional Nurse Manager reported the allegations from the nurse notes to the Administrator. The administrator self-reported the three allegations to the Oklahoma Department of Health on 9/28/22. Person Responsible: Regional Nurse Manager/DON Completed on 10/4/22 5:00 pm Central Time Action Item: Ad hoc QAPI to review POR, and effectiveness with the IDT to include the medical director. Screening, Training, Prevention, Identification, Investigation, Protection and Reporting/response. The review will be documented in the POR Binder. Any revisions or changes will be addressed and reevaluated with findings addressed in QAPI meeting. Person Responsible: Regional Nurse Manager/DON/Regional Director of Operations Completed on 10/4/22 5:00 pm Central Time Action Item: Regional Director of Operations/COO will review the POR to tick and tie the audit tools to validate the POR has been completed by 10/4/22. Person Responsible: Regional Director of Operations/Additional RDO/COO Completed on 10/4/22 5:00 pm Central Time Please accept our plan of removal and lift the jeopardy effective 10/4/2022 . Based on record review, observation, and interview, the facility failed to identify abuse and implement the abuse policy for one (#1) of ten sampled residents who were reviewed for abuse. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Resident Census and Conditions of Residents form identified 100 residents resided in the facility. Findings: The Abuse Prevention Program policy, dated June 2021, read in parts, .The Administrator is responsible for the overall coordination and implementation of our Center's abuse prevention program policies and procedures .As part of the resident abuse prevention program, the administration will: Develop and implement polices and procedures to aid our Center in preventing abuse, neglect, or mistreatment of our residents .Identify and assess all possible incidents of abuse .Protect residents during abuse investigations . The Administrator is the Abuse Prevention Coordinator. In the absence of the Administrator the Director of Nursing will serve in this capacity .During abuse investigations, residents will be protected from harm by the following measures: a. Employees accused of participating in the alleged abuse will be immediately suspended until the findings of the investigation have been reviewed by the Administrator . Resident #1 had diagnoses which included depression and tracheostomy status. The DON's employee record documented the Abuse and Neglect Policy and Procedure was signed by the DON upon hire on 08/15/22. An annual assessment, dated 08/17/22, documented the resident had a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making. On 09/27/22 at 4:30 p.m., Resident #1 stated they heard LPN #1 laughing at and making fun of them when LPN #1 left the room. The resident stated they asked the DON if they were going to do anything about LPN #1 laughing at and making fun of them. Resident #1 stated the DON stated there was nothing they could do about it. On 09/27/22 at 4:56 p.m., The DON was asked if the resident had asked them to do something about the nurse laughing at and making fun of Resident #1. They stated they had instructed the resident to report the allegation to the state surveyors on Monday. The DON stated, I left it at that because I didn't hear it myself. The DON was asked if they had received training regarding abuse. They stated they did not think so but maybe they did when they were hired. On 10/04/22 at 9:58 a.m., the administrator was asked how the facility protected residents from abuse. They stated if they received an allegation of abuse they immediately suspended the employee pending the investigation. The administrator was asked why the abuse protocol was not implemented when the DON had received an allegation of abuse from Resident #1 on 09/24/22. They stated they did not know. The administrator stated they had asked the DON why they had not implemented the policy and the DON reported to them they had not heard the laughing at and making fun of the resident directly. 41809

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	10/04/2022

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35474 On 09/28/22 at 9:38 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to report an allegation of abuse one (#1) when the DON failed to report an allegation of abuse which was reported to them by Resident #1. Resident #1 reported to the DON, with witnesses present, that LPN #1 was making fun and laughing at the resident. The DON failed to report the alleged abuse to the administrator. On 09/28/22 at 9:46 p.m., the facility's administrator, Regional Nurse Manager #1, the Chief Operating Officer, and the corporate Survey Focus Coordinator was made aware of the IJ situation related to the facility's failure to implement the abuse policy. A plan of removal of the IJ situation was requested. A plan of removal was received on 10/04/22 and accepted on 10/06/22. The facility was notified the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of isolated harm. The plan of removal documented: Plan of Removal F609 The facility failed to have a system in place which ensured all the allegations of abuse, neglect, exploitation and/or mistreatment are thoroughly investigated, and measures were immediately put into place to prevent further abuse/neglect. Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 9/28/2022, for abuse reporting/investigating. Action Item: The DON, the nurse and the C.N.A. were suspended on 9/28/22 pending investigation of incident. The DON then stated she was self-terminating. Person Responsible: Regional Nurse Manager Timeline for completion: 10/4/22 5:00 pm Central Time Action Item: Review self-reports from previous 30 days to determine if the investigation has been completed thoroughly. No deficient practice was noted, all investigation were completed and reported to the Oklahoma Department of Health timely. Documentation of this review is in the POR binder. Person Responsible: Chief Operating Officer/Regional Nurse Manager/Administrator Timeline for completion: 10/4/22 5:00 pm Central Time (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: Education of all staff with return demonstration via posttest on abuse prevention, abuse reporting timely, abuse investigation and neglect policies; resident rights and the grievance process and all staff not present will be provided education to starting next shift. All staff will complete abuse skills competency and return demonstration before their next scheduled working shift. Person Responsible: Administrator/Regional Nurse Manager/Unit Manager Timeline for completion: 10/4/22 5:00 pm Central Time Action Item: Safe surveys will be completed with all residents that are interviewable; responsible parties will be phone interviewed for all residents that are not interviewable and those residents will be assessed for signs of physical or psychosocial distress. Person Responsible: Regional Nurse Manager/ ADON/Unit Manager Timeline for completion: 10/4/22 5:00 pm Central Time Action Item: Review of all nurses notes from prior 7-day period to identify any allegations of abuse that were not reported timely. Review of grievance log for the past 30 days. Three allegations were noted from the nurse note review. Zero allegations were noted from the grievance review. The Regional Nurse Manager reported the allegations from the nurse notes to the Administrator. The administrator self-reported the three allegations to the Oklahoma Department of Health on 9/28/22. Person Responsible: Regional Nurse Manager/ADON/Unit Manager/Administrator Timeline for completion: 10/4/22 5:00 pm Central Time Action Item: Ad hoc QAPI to review POR, and effectiveness with the IDT to include the medical director. Medical Director notified by the Regional Nurse Manager of the Immediate Jeopardy and the physician and family member was notified for the resident. The review will be documented in the POR Binder. Any revisions or changes will be addressed and reevaluated with findings addressed in QAPI meeting. Person Responsible: Regional Nurse Manager/DON/ADON/Unit Manager Timeline for completion: 10/4/22 5:00 pm Central Time Action Item: Regional Director of Operations/COO will review the POR to tick and tie the audit tools to validate the POR has been completed and all allegations are investigated and reported timely. Person Responsible: Regional Director of Operations/COO /SFC/RNM Timeline for completion: 10/4/22 5:00 pm Central Time Please accept our plan of removal and lift the jeopardy effective 10/4/2022 . Based on record review, observation, and interview, the DON failed to report an allegation of abuse to the administrator for one (#1) of ten sampled residents who were reviewed for abuse. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Resident Census and Conditions of Residents form identified 100 residents resided in the facility. Findings: The Abuse Prevention Program policy, dated June 2021, read in parts, .The Administrator is responsible for the overall coordination and implementation of our Center's abuse prevention program policies and procedures .An alleged violation of abuse .will be reported immediately, but not later than: Two [2] hours if the alleged violation involves abuse .The Administrator is the Abuse Prevention Coordinator. In the absence of the Administrator the Director of Nursing will serve in this capacity . Resident #1 had diagnoses which included depression and tracheostomy status. The DON's employee record documented the Abuse and Neglect Policy and Procedure was signed by the DON upon hire on 08/15/22. An annual assessment, dated 08/17/22, documented the resident had a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making. On 09/27/22 at 4:30 p.m., The resident stated they asked the DON if they were going to do anything about LPN #1 laughing at and making fun of them. Resident #1 stated the DON stated there was nothing they could do about it. On 09/27/22 at 4:56 p.m., They were asked if they had reported the allegation. The DON stated they had not reported the allegation because they had only heard a conversation between EMSA personnel and the resident. The DON stated, I left it at that because I didn't hear it myself. They stated they had instructed the resident to report the allegation to the state surveyors on Monday. The DON was asked if they had received training regarding abuse. They stated they did not think so but maybe they did when they were hired. They were asked what the types of abuse were. The DON stated verbal, physical, and mental. They were asked if the resident's allegation of the nurse making fun of and laughing at Resident #1 was an allegation which required further investigation. The DON stated they did not know because they had not witnessed the incident. The DON was asked if they had asked the resident or staff for further details regarding the allegation. They stated no. The DON stated they should have gotten a statement but they did not know what the facility's policy was. On 10/04/22 at 9:58 a.m., the administrator was asked what the facility's protocol was if a resident reported an allegation of abuse to a staff member. They stated staff were to immediately report the allegation to the administrator, the employee's supervisor, or the DON. The administrator was asked why the allegation of abuse was not reported to them by the DON per facility protocol. The administrator stated that was their question also. They stated when they asked the DON they had not gotten an answer. The administrator was asked what the time frame was for reporting allegations of abuse. They stated any allegation was to be reported immediately. 41809

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41809 Based on observation, record review, and interview, the facility failed to ensure medications were administered according to physician order for one (#14) and treatments were administered per physician orders for one (#21) of two sampled resident who were reviewed for medications and treatments provided per physician orders. RNM #1 identified 30 residents who received insulin. The Facility Wound Summary Report identified 15 residents with non-pressure wounds. Findings: 1. Resident #14 was admitted to the facility with diagnoses which included, diabetes type two and end stage renal disease. A Physician's Order, dated 08/14/22, documented to administer Novolog Flexpen U-100 Insulin (insulin aspart u-100), via insulin pen, per sliding scale: If Blood Sugar is 150 to 200, give 2 Units. If Blood Sugar is 201 to 250, give 4 Units. If Blood Sugar is 251 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is greater than 350, give 10 Units. If Blood Sugar is greater than 350, call MD. subcutaneous before meals and at bedtime. Resident #14's MAR, dated September 2022, documented the medication was missed 21 times out of 49 opportunities for insuling to be administered per sliding scale since 09/10/22. A Physician's Order, dated 09/01/22 to 09/22/22, documented to administer Levemir FlexTouch U-100 Insulin (insulin detemir u-100) via insulin pen 10 units subcutaneous twice a day. Resident #14s MAR, dated September 2022, documented the medication was missed 15 times out of 42 opportunities for Levemir FlexTouch to be used for insulin administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/22/22 at 12:24 p.m., the DON was asked who monitors to ensure medications are administered as ordered. They stated the nurse and then it escalates if not. The DON was asked how the nurses are to monitor. They stated each shift the nurse monitors to ensure medications are given. The DON was asked if the monitoring was effective. They stated so far they had not noticed a whole lot. The DON was asked why medications were not being administered as ordered by the physician. They stated they had no idea. On 09/22/22 at 12:46 p.m., RNM #1 was asked who was responsible to ensure medications were available and administered. They stated the ADON/DON. RNM #1 was asked how medications were monitored. They stated through the electronic medication administration record compliance report. RNM #1 was asked why medications were not being administered as ordered by the physician. They stated staff had not had anyone to hold them accountable. RNM #1 was asked if monitoring was effective. They stated no. 2. Resident #21 was admitted to the facility with diagnoses which included, paraplegia, peripheral autonomic neuropathy, and type two diabetes. A Physician's Order, dated 08/02/22 to 09/24/22, documented wound care to BLE feet: wash skin with gentle cleanser, apply Dakins solution, gauze and miconazole powder/cream, ABD pad, wrap with Kerlix, and secure with tape, once a day. Resident #21s MAR/TAR, dated September 2022, documented from 09/10/22 to 09/22/22 the treatment was missed three times out of 15 opportunities for wound care to BLE feet, with no explanation provided. A Physician's Order, dated 09/24/22, documented wound care to right foot wash skin with gentle cleanser, apply Dakins solution soaked gauze and miconazole powder/cream, ABD pad, wrap with Kerlix, and secure with tape, once daily. Resident #21s MAR/TAR, dated September 2022, documented the treatment was missed once out of seven days for wound care to be completed to right foot. Resident #21s Care Plan, revised 09/05/22, documented an approach start date of 08/19/2022 and read in part, .I prefer to take my shower daily secondary to my diagnosis related to bilateral lower legs and feet . Resident #21s MAR/TAR, dated October 2022, documented the treatment was missed twice to the right foot, the first and second of October. The explanation provided in the clinical record read, Not Administered: Refused Comment: Resident refused shower and dressing change today, said he will do both tomorrow. On 10/02/22 at 9:28 a.m., Resident #21s dressings to their bilateral feet were observed to be dated 09/30/22. The resident was asked when wound care was last provided. They stated Friday 09/30/22. They were asked how often wound care was ordered. They stated daily. Resident #21 was asked why wound care had not been provided 10/01/22. They stated because they had not received their shower. They stated they were suppose to receive a shower daily and then receive wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/22 at 9:08 a.m., Resident #21s dressings to bilateral feet were observed to have a dressing dated 09/30/22 and initialed BW. On 10/03/22 at 9:38 a.m., CNA #6 with CNA #7 present, was asked if Resident #21 had refused a shower over the weekend. The CNA #6 stated they did not know the resident needed a shower. CNA #7 stated Resident #21 gets a shower seven days a week for wound care. CNA #7 was asked if the wound nurse was at the facility over the weekend. They stated no, so the nurse should have done the dressing. On 10/03/22 at 9:47 a.m., CNA #8 was asked if they had given Resident #21 a shower on the weekend. They stated no, that they heard the resident will ask every day. The CNA #8 stated the resident did not get a shower on Saturday because they were bombarded and did not get to it. The CNA #8 re-stated, the resident did not refuse, they could not get to him. On 10/03/22 at 9:57 a.m., LPN #3 was asked if they worked the weekend (10/01/22 & 10/02/22). They stated they were off on Saturday and worked Sunday 7:00 a.m. to 7:00 p.m. They were asked why Resident #21's dressings were not done on Sunday. They stated they did not have adequate supplies and did not have access to the treatment cart. The LPN stated the resident had not had a shower and stated they would have a shower and wound care Monday, 10/03/22. LPN #3 was asked if the resident had refused. They stated the resident just said he would wait until after his shower today 10/03/22. They stated the resident was waiting on a shower and I dropped the ball. On 10/03/22 at 10:55 a.m., CNA #7 prepped Resident #21 for a shower, both feet were observed to be not wrapped and covered with a towel. On 10/03/22 at 12:07 p.m., wound nurse #2 was asked who does treatments and dressing changes. The nurse stated themselves or the charge nurse. The wound nurse was asked who did the dressing changes on the weekend. Wound nurse #2 stated the charge nurse or floor nurse. The wound nurse was asked if supplies were available on the weekend. They stated the nurses have a treatment cart, and if it is low, it gets refilled by the wound nurse. The wound nurse was asked how often Resident #21s dressings were ordered to be changed. The wound nurse stated daily. The wound nurse was asked why they were not changed on 10/01/22 and 10/02/22. They stated they were not here and could not attest to why they were not done. They were asked who was responsible to ensure the treatment was done. Wound nurse #2 stated the weekend manager on duty and DON. On 10/03/22 at 4:32 p.m., RNM #1 was asked why Resident #21 did not have his dressing to his feet changed over the weekend. They stated the resident had refused initially due to wanting a shower. RNM #1 was asked who informed them the resident refused. They stated CNA #6 reported the resident had refused a shower. RNM #1 stated LPN #3 reported to them wound supplies were not available. RNM #1 was asked if the resident had to have a shower before the wound care could be done. They stated yes, their whole body needed washed due to the wounds were caused by a fungus.

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	375568	A. Building B. Wing	10/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 09/15/22 at 5:53 p.m., an Immediate Jeopardy (IJ) was identified and verified by the Oklahoma State Department of Health (OSDH). The facility was notified at 6:10 p.m., of the Immediate Jeopardy regarding the treatment and services to prevent/heal pressure ulcers for three (#3, 9, and #10) of three sampled residents who were reviewed with pressure ulcers. The facility failed to administer treatment/services to prevent infection and the development of new pressure ulcers. The facility failed to identify pressure ulcers, ensure physician notification was made and documented, ensure treatment orders were in place for each wound, ensure treatments were followed per physician order, and ensure all nursing staff received education regarding recognizing signs and symptoms of infection. A Plan of Removal (POR) was received on 10/04/22. The facility was notified on 10/06/22 at 2:48 p.m. the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of harm. The Plan of Removal documented: Plan of Removal Pressure ulcers Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 9/15/22 for Treatment/services to prevent infection and development of new pressure ulcers. Action Items 1: All residents had a skin assessment completed by nursing staff by 9/16/22 at 8:00pm central time. Weekly skin assessments will be completed by the staff nurse and verified by charge nurse and/or ADON. Skin assessments are completed on all residents weekly. Skin assessments are documented in Matrix. Skin assessments populate in Matrix on the scheduled day of the skin assessment. The nurse completing the skin assessment, documents in Matrix and is required to electronically signed in the electronic medical record. The wound report tool will be reviewed weekly by the resident at risk team. The resident at risk team consists of nurses, operators, social services and dietary. The review will consist of completion of skin assessments and the condition of the wounds. Recommendations of the team will be addressed by the nurse. The nurse will contact the medical director and or physician to review changes and implement orders as needed DON/ADON(s), charge nurses, and wound nurse(s) were educated on facility wound care policy and procedures by Regional Clinical Nurse RN/DON/ADON/Unit Manager Completed on 10/4/22 5:00 pm Central Time (continued on next page)

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	375568	A. Building B. Wing	10/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Regional Clinical Nurse, RN will begin rounding with wound nurse x2 weekly. RN Regional Nurse 2 is assigned as the backup regional nurse in the center to cover the regional clinical nurse that is assigned to this center, shall they not be available. Wound round reports will be reviewed by the DON and ADONs during the daily clinical meeting which is conducted daily-7 days a week. Wound reports will be reviewed/verified by Clinical Resource Nurse, RN/DON/ADON/Unit Manager each day following daily clinical meeting, which is conducted 7 days a week. Action Item 2: All resident admission assessments were reviewed for completion on 9/15/22 by 9:45pm central time by Corporate Resource Nurse(s) RN. Regional Nurse Manager, RN/DON/ADON/Unit Manager will review all admits and readmits daily during morning clinical meeting for accuracy and completeness. Nurses were re-educated on pressure ulcers, interventions, assessments, Braden scale, documentation, completing physician orders as prescribed, physician notification, and treatments. Completed on 10/4/22 5:00 pm Central Time The RN Corporate Resource Nurse(s)/DON/ADON/Unit Manager will complete the education. Nurses, C.N.A and CMA's received education regarding the recognition of signs and symptoms of infection, areas of skin concern, change of condition/status, how to communicate concerns with charge nurse, ADON and/or physician. The Nurses were also educated on physician orders, electronic medication entry into the EMAR. The regional nurse manager education team consisted of seven regional nurse managers, RN. Re-education was completed with 1-2 staff members at a time. The wound module is part of the Matrix training. For Nurses/C.M.A./C.N.A. and other non-clinical staff came in before their shift started, during their shift and stayed after their shift. The staff that are unavailable due to not being scheduled for various reasons and or not answering their phone will be re-educated prior to working their next shift. Completed on 10/4/22 5:00 pm Central Time Action Item 3: Residents receiving IV antibiotics were reviewed to ensure antibiotic orders have been followed as prescribed by the RN Clinical Resource Nurse(s) concerns identified during this review will be addressed by DON/ADON/Unit Manager to include the nurse involved and documented on audit tool in POR Binder completed on 10/4/2022 5:00 pm Central Time. Any new antibiotic orders and changes to antibiotic orders will be reviewed by the DON/ADONs during the morning clinical meeting, and the nurse manager on the weekend. If an order has not been followed the policy/procedure for a missed medication will be completed. This includes an event observation and notification to the family and physician. Regional Nurse Manager, RN will validate all new antibiotic orders daily. RN Regional Nurse 2 is assigned as the backup regional nurse in the center to cover the regional clinical nurse that is assigned to this center, shall they not be available. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action Item 4: Resident #3 has been in the hospital for wound management since 9/2/22. The Corporate Resource Nurse, RN obtained a physician order to transport resident #9 and resident #10 to the ER for evaluation. Both residents returned to the facility same day without new orders. Action Item 5: Follow up wounds, and antibiotic treatment reviews will be held by the Administrator and DON during the weekly Resident at Risk Team on Wednesdays at 3:00pm CST. Regional Director of Operations will review Administrators/DON Resident at Risk findings weekly. Review will be kept in the POR/POC binder. Review consists of the meeting occurring and the residents at risk were reviewed. All Resident at Risk documentation and actions will be presented to the QAPI Committee monthly. The center does not use agency staff, if the center utilizes agency staff or hires new staff, staff will complete the appropriate education prior to working on the floor. Education will be completed by the Regional Nurse Manager, RN/DON, RN/Nurse manager RN/LPN. Completed on 10/4/22 5:00 pm Central Time Based on observation, record review, and interview, the facility failed to identify pressure ulcers, ensure physician notification was made and documented, ensure treatment orders were in place for each wound, ensure treatments were followed per physician order, and ensure all nursing staff received education regarding recognizing signs and symptoms of infection for three (#3, 9, #10) of three residents identified with pressure ulcers. The Resident Census and Conditions of Residents form identified eight residents had pressure ulcers. Findings: A Prevention of Pressure Injuries policy, dated May 2022, read in parts, .Monitoring .Evaluate, report and document potential changes in the skin .Review the interventions and strategies for effectiveness on an ongoing basis . 1. Resident #3 admitted to the facility on [DATE] with diagnoses which included, obesity and skin tears to the left lower shin and right forearm. A Progress Note, dated 08/01/22 at 1:30 p.m., documented Resident #3 had a stage II pressure injury from a lengthy stay on a toilet at home, skin tears to left lower shin area, and lower right forearm. Review of the resident's clinical record did not reveal an admission assessment had been completed or a skin assessment prior to 08/12/22. (continued on next page)

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	375568	A. Building B. Wing	10/04/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility Wound Management report, dated 08/12/22, documented a deep tissue injury of 11 x 6 cm to the right buttock was identified. A Physician's Order, dated 08/12/22 to 08/23/22 documented to clean sacrum with normal saline/wound cleanser, apply medihoney, and cover with bordered foam dressing every Monday, Wednesday, and Friday. The Medication Administration Record, dated August 2022, documented Resident #3 had not received the wound treatment two times (on 08/12/22 and 08/22/22) out of five opportunities to the sacrum. The Care Plan, dated 08/25/22, documented Resident #3 was at risk for pressure ulcer due to moisture. The goal for Resident #3 was documented as the resident was to have intact skin without evidence of redness, irritation, maceration, or open areas. The approach documented to check incontinence pads frequently (every 2-3 hours) and change as needed. A Physician's Order, dated 08/26/22, documented to clean Resident #3's sacrum with normal saline/wound cleanser, apply Triad barrier paste, and cover with border foam dressing daily. The Medication Administration Record, dated August 2022, documented the resident had not received the treatment two times (on 08/27/22 and 08/28/22) out of six opportunities to the sacrum. Review of the clinical record revealed a discharge return anticipated assessment dated [DATE], documented Resident #3 was discharged to the hospital. A hospital Trauma Surgery Consult Note, dated 09/07/22, read in parts, .[Resident #3] is a 74 y.o. male who presents with stage 4 decubitus sacral wound. Impression and Plan: Infected stage IV sacral wound 1. Agree with antibiotics per primary team 2. Plan to proceed to OR for I&D of sacral wound 09/08/22 .Infectious disease has requested that we obtain a culture of the wound . On 09/12/22 at 10:05 a.m., wound nurse #2 was asked about Resident #3's skin. They stated on admission the resident had wounds on their shin and arm. The wound nurse stated the deep tissue injury developed at the facility, but on admission there was only excoriation and it was treated with barrier cream and not open. Wound nurse #2 was asked how Resident #3's wounds progressed. They stated they had done the original skin check on admission. The wound nurse was asked where the original skin check was documented. They stated it was documented in wound manager. The wound nurse stated they were alerted by the nurse on 09/12/22 when the new deep tissue injury was in the system and it was not small, it was at least 14 centimeters across. (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	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/13/22 at 10:35 a.m., the wound nurse #1 was asked about the skin condition on admission for Resident #3. They stated on the day after admit a small blanchable area was noted and treated with barrier cream. Wound nurse #1 stated they did not document clear skin and only documented by exception. Wound nurse #1 stated on 09/12/22 they received a text to evaluate the skin condition for Resident #3 and noted a DTI to the sacrum. Wound nurse #1 was asked if skin assessments had been completed between 08/01/22 and 08/12/22. They stated they did not know. Wound nurse #1 was asked how often skin assessments were to be completed. They stated weekly. Wound nurse #1 was asked when they had last observed the sacrum of Resident #3. They stated they had seen it the day Resident #3 went to the hospital and noted necrosis and deterioration. Wound nurse #1 stated the wound had opened up with drainage and an odor was present, but not foul. Wound nurse #1 was asked how the physician was involved in treatment changes. They stated, He is notified, being we are both certified he trusts our judgement. On 09/13/22 at 11:31 a.m., ADON #1 was asked who performed the admission assessment. They stated the floor nurse would be responsible. ADON #1 was asked how it could be determined who completed the admission process. They stated there should have been an admission note entered under the observation tab of the clinical record. On 09/14/22 at 11:24 a.m., RNM #1 was asked when admission skin assessments were to be completed. They stated on the day of admission. RNM #1 was asked if an admission assessment had been completed for Resident #3. They stated one should have been completed and documented in the clinical record. RNM #1 stated the wound nurse had completed the admission skin assessment but had not documented in the clinical record. 2. Resident #9 was admitted to the facility with diagnoses which included dementia and osteomyelitis. A wound physician progress note, dated 05/05/22, documented a sacral wound had been identified and an order for treatment was recommended. The order was not entered into the clinical record. No documentation was provided that the order had been reviewed by the physician or medical director. A facility Wound Management note, dated 07/31/22, identified the sacral wound at a stage III with measurements of 1.5 x 2 x 1 cm. The Medication Administration Record, dated 08/01/22 to 08/19/22, documented the resident's sacral wound care had not been provided three times (08/01/22, 08/03/22, and 08/16/22) out of seven opportunities to the sacral wound. On 08/04/22, the facility documented a measurement of 1.5 x 2 x 1 cm for the stage III sacrum. A wound physician progress note, dated 08/29/22, documented a stage IV to the sacrum with measurements of 2 x 3.0 x 0.9 cm with undermining of 2.7 cm at four o'clock and wound progress as deteriorated. The wound physician progress note documented the dressing treatment plan for the stage IV to the sacrum was to apply calcium alginate daily and cover with a gauze island dressing. The dressing treatment plan was not implemented. On 08/31/22, the facility documented the sacral wound measurement as 1.5 x 1.5 x 1 cm and was unstageable with undermining of 2.6 cm, no direction of the undermining was documented. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Physician's Order, dated 09/01/22, documented to administer Triad cream to the perineal area for MASD for Resident #9. The Medication Administration Record, dated 09/01/22 to 09/12/22, documented the resident had not received the treatment four times (09/01/22, 09/02/22, 09/03/22, and 09/10/22) out of 12 opportunities to the perineal area. A Physician's Order, dated 09/01/22, documented to cleanse the stage IV to the sacrum with normal saline/wound cleanser, apply medihoney, and cover with bordered foam. The Medication Administration Record, dated 09/01/22 to 09/12/22, documented the resident had not received the treatment four times (09/01/22, 09/02/22, 09/03/22, and 09/10/22) out of 12 opportunities to the sacrum. On 09/07/22, the facility documented the sacral wound measurement as 1.4 x 1.3 x 0.7 cm, was unstageable and undermining of 2.1 cm. No direction of the undermining was documented. A wound physician progress note, dated 09/08/22, documented the visit for Resident #9 was rescheduled. The wound was discussed with the wound nurse and the wound was stable from the prior exam. Measurements were provided of 1.4 x 1.3 x 0.1 cm with tunneling of 1 cm at 12:00 and 2:00. A wound physician progress note, dated 09/12/22, documented the sacral wound as a stage IV, full thickness wound, with measurements of 1.5 x 2.5 x 0.9 cm with undermining of 2.7 cm at four o'clock, with no change in wound progress. The wound physician progress note documented the dressing treatment plan for the stage IV to the sacrum was to apply calcium alginate daily and cover with a gauze island dressing. The dressing treatment plan was not implemented. On 09/13/22 at 5:36 p.m., wound nurse #1 and wound nurse #2 were observed to administer wound treatments to Resident #9. During the treatment two additional wounds were present that had not been previously identified, according to physician orders. Both wounds were treated by wound nurse #1. The first unidentified wound was to the sacrum. The second unidentified wound was to the left lateral side, proximal to the last rib. The wound measured 1 x 1 cm, with a crescent shaped wound directly under the circular wound. They were red in color and unblanchable. They were located where the resident had previously been laying on their peg tube. On 09/13/22 at 6:12 p.m., wound nurse #1 was asked what wounds were treated. They stated the sacral wound and the back of the head, but the back of the head had healed and they needed to resolve it in the system. Wound nurse #1 stated the hip excoriation was not as bad the day before and a new area on Resident #9's side was identified today. The wound nurse was asked if there were any other new areas noted. They stated the excoriation. The wound nurse was asked where it was documented. They stated they would have to check the list of things to do. The wound nurse was asked what was on the treatment order for the new open area to the sacrum. The nurse stated nothing was documented or entered in the clinical record yet. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/15/22 a 12:39 p.m., the DON with RNM #1 present, was asked who provided wound treatment orders. The DON stated the wound doctor and the medical director. The DON was asked how orders were received from the wound doctor. The DON stated they were not sure. RNM #1 stated the wound doctor made recommendations and the medical director reviewed them. RNM #1 stated if the medical director approved the orders they were entered in the electronic system, if the orders were not approved they would automatically delete from the system. On 09/16/22 at 10:29 a.m., RNM #1 with the administrator present, stated wound nurse #1 had identified the new wounds for Resident #9, but had not entered them in the electronic system so they technically were not identified due to no treatment orders. A wound physician progress note, dated 09/19/22, documented the the sacral wound as a stage IV, full thickness wound, with measurements of 1.5 x 2.5 x 0.9 cm with undermining of 2.7 cm at four o'clock. The wound physician progress note documented the wound progress as deteriorated. The wound physician progress note documented the dressing treatment plan for the stage IV to the sacrum was to apply sodium hypochlorite gel once daily and cover with gauze island dressing. The treatment order was not implemented. On 09/21/22 at 2:03 p.m., the medical director was asked how the wound doctor's orders/recommendations were addressed. The medical director stated they deferred to the wound physicians as they were general surgeons and their recommendations were considered orders that the medical director just signed. 3. Resident #10 was readmitted to the facility on [DATE] with diagnoses which included osteomyelitis, chronic pain, and stage IV pressure ulcers. A Physician's Order, dated 07/27/22, documented to administer Avycaz (ceftazidime-avibactam) (an antibiotic medication) 2.5 gm daily intravenously until 08/28/22. The Medication Administration Record, dated August 2022, documented the resident missed eight out of 28 opportunities for the medication Avycaz on 08/01/22, 08/04/22, 08/05/22, 08/06/22, 08/07/22, 08/15/22, 08/16/22, and 08/19/22 . The Care Plan, dated 08/23/22, documented to prevent/heal pressure sores and skin breakdown by providing treatment as ordered. No interventions were listed on the care plan. The Medication Administration Record, dated September 2022, documented from 09/01/22 to 09/13/22 Resident #10 had not received wound treatments to his left heel, left ischium, and right ischium five times (on 09/01/22, 09/02/22, 09/03/22, 09/05/22, and 09/10/22) out of 12 opportunities, with no explanation documented. The order frequency was changed on 09/13/22 for wound care to be provided on Monday, Wednesday, and Friday. No documentation was provided in the clinical record with explanation for the change in the frequency or of communication with the physician. On 09/13/22 at 10:35 a.m., wound nurse #1 and wound nurse #2 were asked how the physician was involved with wound care. They stated they notified the physician. The nurses were asked why wound treatments were changed from daily to Monday, Wednesday, and Friday for Resident #10. They stated, Since we are both certified wound nurses, he trusts our judgement. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/13/22 at 2:17 p.m., Resident #10 stated their wound dressings were completed daily. The dressings were observed to be dated 09/12/22. The coccyx dressing appeared to have pulled away from the wound, leaving it partially exposed. The resident stated they were taking antibiotics to fight an infection in their wounds on their buttocks and coccyx. On 09/14/22 at 4:18 p.m., wound nurse #2 was observed to provide treatments to the wounds for Resident #10. A foul odor was detected when wound nurse #2 removed the dressing from the ischial and sacral wounds. During the treatment of the sacral and ischial wounds the wound nurse stated an open area above the sacral wound, a wound to the meatus of the penis, and an area to the left lateral foot had not been previously identified. Wound nurse #2 stated they would inform the physician of the slough and biofilm in the ischial and sacral wound beds and the previously unidentified wounds. The wound nurse did not state the odor of the wounds would be reported to the physician. On 09/15/22 at 12:39 p.m., the DON with RNM #1 present, was asked who provided wound treatment orders. The DON replied the wound doctor and the medical director. The DON was asked how orders were received from the wound doctor. The DON stated they were not sure. The RNM #1 stated the wound doctor made recommendations and the medical director reviewed them and if the medical director approved the orders they were entered in the electronic system, if the orders were not approved they would automatically delete from the system.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35474 On 09/16/22 at 3:00 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to identify, implement, monitor, and modify interventions to prevent a severe weight loss. Resident #9 experienced a severe weight loss of 16.26% in one month and the facility failed to monitor weights, monitor enteral feeding, and implement interventions. On 09/16/22 at 3:18 p.m., the facility's administrator, Regional Director of Operations, Regional Nurse Manager #1, Regional Nurse Manager #2, and the DON was made aware of the IJ situation related to the facility's failure to prevent severe weight loss. A plan of removal of the IJ situation was requested. A plan of removal was received on 10/04/22 and accepted on 10/05/22. The facility was notified the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of isolated harm. The plan of removal documented: Plan of Removal significant weight loss Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 9/16/22 for residents who received enteral feeding and weight loss. Action Item 1: Resident #9 was immediately re-assessed by RN Clinical Resource Nurse for proper tube feeding procedures and proper positioning, deficient practice corrected. All residents with enteral feedings were weighed between 9/15/22 and 9/17/22. Corporate Resource Nurse(s) RN, reviewed enteral feeding resident weights for significant weight loss and variances on 9/17/22 completed by 5:00pm central time Residents receiving tube feedings with weight variance were placed on a weekly weight schedule x4 weeks by the Corporate Resource Nurse(s), RN on 9/17/22 completed on 10/4/22 5:00 pm Central Time DON/Regional Nurse Manager, RN will review Dietitian enteral feeding recommendations on day received. Enteral feeding recommendations will be transmitted to the resident physician for review/approval within 24 hours of receipt. Any physician orders for enteral feeding changes will be reviewed during daily morning clinical meeting by the DON/Regional Nurse Manager, RN and implemented immediately. The DON/Regional Nurse Manger will review the previously mentioned on the weekends. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Weekly weights will be reviewed by the DON/Regional Nurse Manager, RN during the morning clinical meeting. Weights are completed by the designated CNA. Weights are documented by Nurse Manager in Matrix, weights are entered by every Thursday by 5:00 pm. DON/Regional Nurse Manager will review the weight process the following day and the regional nurse/regional nurse 2 will validate the process. Follow up weekly weight reviews will be held by the Administrator & DON every Wednesday at 3:00pm central time with the Resident at Risk Team in the clinical management office. Identified residents at risk will be reviewed for interventions, recommendations by the team/physician. Regional Director of Operations will review Administrator & DON Resident at Risk team findings weekly. This will be reviewed in QAPI for process improvement. All Residents at Risk documentation and action(s) taken will be presented to the QAPI Committee monthly. Action Item 2: Nursing staff was educated by Corporate Resource Nurse(s) on significant weight loss, interventions, physician notifications, entering physician orders into the electronic medication administration education for nurses completed on 10/4/22 5:00 pm Central Time The regional nurse manager education team consisted of seven regional nurse managers, RN. Education was completed with 1-2 staff members at a time. The wound module is part of the Matrix training. For Nurses/C.M.A./C.N.A. and other non-clinical staff came in before their shift started, during their shift and stayed after their shift. The staff that are unavailable due to not being scheduled for various reasons and or not answering their phone will be educated prior to working their next shift. The RN Corporate Resource Nurse(s)/DON or Unit Managers will complete the education. Clinical staff-Nurses, CNAs, and CMAs was educated on repeated meal refusals, repeated meal intake of less than 50%, recognition of signs of decreased appetite and signs of weight loss by RN Clinical Resource Nurse(s). Education for nurses completed on 10/4/22 5:00 pm Central Time. The RN Corporate Resource Nurse(s)/DON or Unit Managers will complete the education. The regional nurse manager education team consisted of seven regional nurse managers, RN. Education was completed with 1-2 staff members at a time. The wound module is part of the Matrix training. For Nurses/C.M.A./C.N.A. and other non-clinical staff came in before their shift started, during their shift and stayed after their shift. The staff that are unavailable due to not being scheduled for various reasons and or not answering their phone will be educated prior to working their next shift. The center does not use agency staff, if the center utilizes agency staff or hires new staff, staff will complete the appropriate education prior to working on the floor. Education will be completed by the Regional Nurse Manager, RN/DON, RN/Nurse manager RN/LPN. Please accept our plan of removal and lift the jeopardy effective 10/4/2022 . Based on observation, record review, and interview, the facility failed to assess, monitor, and intervene for one (#9) of three residents sampled for weight loss. This resulted in the resident experiencing a severe weight loss of 16.26% in one month. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Regional Nurse Manager #1 identified seven residents with significant weight loss. Findings: The Enteral Nutrition policy, dated November 2018, read in parts, .Adequate nutritional support through enteral nutrition is provided to residents as ordered .The nurse confirms that orders for enteral nutrition are complete . The Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol policy, dated September 2017, read in parts, .The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time .The staff will report to the physician significant weight gains or losses . Resident #9 had diagnoses which included dementia. The Weight Variance Report, dated 03/15/22 through 09/15/22, documented the latest weight for Resident #9 was 99.2 pounds on 08/16/22. No weight was documented for September 2022. The Medication Administration Record, dated 08/01/22 through 08/31/22, did not document any orders for continuous or bolus tube feeding. The MAR documented the resident was NPO. A Resident Progress Note, dated 08/18/22, read in part, .CBW: 99.2# .NPO. Jevity 1.5 @40ml x22hr providing 1320kcal, 56g pro, 668ml fluid. Flushes 200cc q 6 hours (1200ml fluid). Tolerating feeds .EEN: 1115kcal, 40-50g pro, 1350-1575ml fluid .likely not meeting adequate intake with continuing decline. Rec 1. Increasing Jevity 1.5 @ 55ml x 22hr Providing 1815kcal, 77g pro, 919 free H2O. Will continue to monitor. The progress note was signed by the registered dietician. Review of the clinical record did not reveal the physician had addressed the dietary progress note. A Daily Census Report, dated 08/30/22, was provided to the survey team as a list of weights for September 2022 by RNM #1. RNM #1 stated at the end of the month they printed a daily census report, which was provided to the nurse aide who was responsible for obtaining weights, for the following month. Resident #9 was not on the list. A Resident Progress Note, dated 08/31/22 at 3:34 p.m., documented the resident had returned from the hospital. The note read in part, .will administer feeds as per orders . A Resident Progress Note, dated 08/31/22 at 6:44 p.m., documented the nurse attempted to hook the resident to the feeding pump but the pump gave an error message and another pump could not be located. A Resident Progress Note, dated 08/31/22 at 7:07 p.m., documented the physician had been made aware the feeding pump was not functional and orders were received for Jevity 1.5 240ml via peg tube four times per day, flush with 100ml of water, and to resume continuous feeding orders once another pump was obtained. An admission assessment, dated 09/04/22, documented the resident was severely impaired in cognition for daily decision making, weight loss/gain was not experienced or unknown, and they had a feeding tube. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Physician Order Report, dated 09/01/22 - 09/22/22, read in part, .Dietary flow sheet .Enteral Formula Pump Administration: Jevity 1.5 to run at 40 Ml/Hour for 22 hours per day . The order was dated 08/26/22 through 09/01/22. The Medication Administration Record, dated 09/01/22 through 09/22/22, documented a physician order for Glucerna 1.2 per peg 240ml with 100ml water flushes four times a day as needed for a broken pump. Review of the MAR did not reveal documentation the resident had received the Glucerna 1.2 from 09/01/22 - 09/16/22. On 09/13/22 at 8:23 a.m., the resident was observed in bed. The feeding pump was observed to be off. A bottle of Glucerna was hanging on the feeding pump. The bottle had a hand written date of 09/01 or 09/11, the day was smudged. The bottle contained 400 cc of formula. On 09/13/22 at 4:16 p.m., the resident was observed in bed. The feeding pump was observed to be off with no formula hanging. On 09/15/22 at 9:51 a.m., the feeding tube was not connected. The resident was observed in bed with the enteral feeding pump infusing at 40 cc/hr. The end of the feeding tube was observed to not be connected to the resident and was infusing under the resident's bed. A pool of light tan liquid was observed on the floor, at the end of the feeding tube. On 09/15/22 at 10:54 a.m., the enteral feeding pump was observed infusing at 40 cc/hr. The end of the feeding tube was observed to be under the resident's bed. A pool of light tan liquid, was observed from the hallway on the floor at the end of the feeding tube. On 09/15/22 at 11:48 a.m., the enteral feeding pump was observed infusing at 40 cc/hr. The end of the feeding tube was observed to be under the resident's bed. A pool of light tan liquid, was observed from the hallway on the floor at the end of the feeding tube. On 09/15/22 at 12:15 p.m., the enteral feeding pump was observed infusing at 40 cc/hr. The end of the feeding tube was observed to be under the resident's bed. A pool of light tan liquid, was observed from the hallway on the floor at the end of the feeding tube. On 09/15/22 at 1:32 p.m., the enteral feeding pump was observed infusing at 40 cc/hr. The end of the feeding tube was observed to be under the resident's bed. A pool of light tan liquid, was observed from the hallway on the floor at the end of the feeding tube. The enteral feeding pump documented the resident had received 1778 cc and had received 1103 cc of fluid. On 09/15/22 at 2:02 p.m., observed LPN in room. LPN #1 was asked what care they were providing to Resident #9. They stated they were changing the enteral tube feeding set, water, and formula. The LPN pulled the blankets off of the resident and observed the tube was not connected. The LPN was asked about the area of the floor at the end of the feeding tube. They stated the floor appeared wet. LPN #1 was asked how long the resident's tube feeding had not been infusing into the resident. They stated the CNAs had repositioned the resident about one hour ago and they may have unhooked it at that time. The LPN stated the resident was repositioned every two hours. LPN #1 was asked how they knew what the resident's enteral feeding physician orders were. They stated they knew the resident was ordered 40cc/hr and could be off for two hours for care. They were asked if they had administered bolus enteral feedings. LPN #1 stated no. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/15/22 at 2:14 p.m., CNA #1 was asked about the resident's tube feeding. They stated the tube feeding had been leaking. They stated the feeding pump said the formula was running but the resident wasn't getting any food. They were asked when they had noticed the tube feeding was leaking. They stated around 11:00 a. m. CNA #1 was asked if they had notified anyone about the enteral feeding not infusing. They stated LPN #2. On 09/15/22 at 2:18 p.m., RNM #1 was asked when weights were obtained. They stated monthly weights were obtained the first few days of the month, upon return from the hospital, and as needed. RNM #1 was asked where the weights were documented. They stated they were documented on paper then added to the electronic clinical record under vital signs. RNM #1 was asked why the weight for Resident #9 had not been obtained upon return from the hospital on 08/31/22 or the monthly weight for September 2022. They reviewed the list of monthly weights and stated they did not know. RNM #1 was asked for the resident's current weight. On 09/15/22 at 3:47 p.m., CNA #1 obtained the weight for Resident #9 via mechanical lift. The weight was observed and reported as 82.94 pounds. This weight indicated a 16.26% weight loss in one month. On 09/15/22 at 4:16 p.m., LPN #2 was asked if anyone had reported any issues with Resident #9's enteral feeding not infusing. They stated not that they remembered. They were asked if they had provided care to Resident #9. They stated they had worked on the resident's hall for a few hours but had not provided care to the resident. LPN #2 stated the nurse who had been assigned to the hall wanted a different hall so they covered until another nurse took over. On 09/16/22 at 9:28 a.m., a bottle of Glucerna was observed to be connected to the enteral feeding pump. The bottle of Glucerna, dated 09/15/22 at 2:05 (a.m. or p.m. was not indicated), was observed to contain 600 cc of formula. The pump was observed to be set at 40 cc/hr with a 100 ml water flush. The pump read the resident had been fed 222 ml. On 09/16/22 at 10:53 a.m., RNM #1 was asked where continuous and bolus enteral feedings were documented. They stated on the MAR. They reviewed the electronic record and stated the orders for the enteral tube feeding was listed on the dietary flow sheet. RNM #1 contacted the IT department and asked how nurses were able to see the resident's tube feeding orders when it was documented on the dietary flow sheet. RNM #1 stated the nurses were not able to see the resident's enteral feeding orders when they were located on the dietary flow sheet. RNM #1 stated there was not a place to document the administration of the enteral tube feeding administration on the dietary flow sheet. RNM #1 was asked where bolus enteral feedings from 09/01/22 through 09/16/22 were documented for Resident #9. They stated on the electronic MAR. They reviewed the MAR and was asked how often the resident had received a bolus enteral feeding. RNM #1 stated, Zero. RNM #1 was asked how tube feeding was monitored to ensure the resident had received enteral feeding as ordered by the physician to maintain nutrition and prevent weight loss. They stated there was no way to know the enteral feeding had been administered as ordered by the physician. RNM #1 stated they did not know if anyone had monitored. On 09/21/22 at 2:03 p.m., the medical director was asked how they received and addressed dietary recommendations from the dietician. They stated there was a system in place and it was a part of a continuous quality assurance. The medical director stated the recommendations were placed in a folder for them to sign. The medical director was asked how they were aware of weights to monitor for significant weight loss. The medical director stated they reviewed monthly weights. (continued on next page)

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	375568	A. Building B. Wing	10/04/2022

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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/21/22 at 3:21 p.m., RNM #1 was asked how residents' weights were monitored to ensure significant/severe weight loss was identified. They stated they had a book where weights were documented before they were placed in the electronic clinical record. RNM #1 stated the weights were inaccurate because sometimes the residents were weighed with the mechanical lift and sometimes the wheel chair weight had not been deducted. 41809

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 35474 On 09/16/22 at 3:00 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to prevent aspiration with proper positioning for residents who received enteral nutrition. Resident #3 was found to be lying supine by the treatment nurses with continuous enteral feeding infusing. As a result of lying supine, the resident was transferred to the hospital and was diagnosed with aspiration pneumonia. Resident #9 was observed lying supine with a continuous tube feeding infusing. On 09/16/22 at 3:18 p.m., the facility's administrator, Regional Director of Operations, RNM #1, RNM #2, and the DON was made aware of the IJ situation related to the facility's failure to prevent aspiration pneumonia with proper positioning of residents who received enteral tube feeding. A plan of removal of the IJ situation was requested. A plan of removal was received on 10/05/22 and accepted on 10/06/22. The facility was notified the immediacy was lifted as of 10/04/22 at 5:00 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a level of isolated harm. The plan of removal documented: Plan of Removal Tube feeding Please accept this Plan of Removal as a credible allegation of compliance for the immediate jeopardy initiated on 9/16/22 for adequate nutritional tube feeding and administrating tube feedings. Action Items: Resident #9 was immediately assessed by the Clinical Resource Nurse, RN for proper tube feeding procedures and proper positioning, deficient practice corrected. Resident #3 was transported to the hospital on 9/2/22 and remains an in patient. Other residents with enteral feedings were reviewed for proper tube feeding and proper positioning per the physician order and verified that the order is visible on the medication administration record by the Corporate Resource Nurse(s), RN on 9/16/22 completed by 8:00pm central time. Charge nurse/ADON/nurse manager will monitor all residents who receive enteral feedings to ensure the correct formula, rate, and correct positioning of residents q shift daily by visual inspection and document in EMR. Nursing documentation will be reviewed and validated during daily morning clinical meetings by the DON and ADON for each hall assignment. The nurse manager/ADON will complete the assigned duties previously mentioned above, on the weekend. Night shift nurse manager/charge nurse LVN will complete the assigned duties previously mentioned above daily. Verification of reviews conducted during daily morning clinical meeting of nursing documentation by DON/ADON will be conducted by the Administrator & Regional Nurse Manager, RN every Wednesday at 3:00pm CST with the Resident at Risk Team in the clinical management office. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dietitian enteral feeding recommendations and enteral physician orders were reviewed and corrected if needed by Director of Nursing/Clinical Resource Nurse(s), RN on 9/16/22 completed by 8:00pm central time. DON/Regional Nurse Manager, RN will review Dietitian enteral feeding recommendations on day received. Enteral feeding recommendations will be transmitted to the resident physician for review/approval within 24 hours of receipt. Any physician orders for enteral feeding changes will be reviewed during daily morning clinical meeting by the DON/Regional Nurse Manager, RN and implemented that day. Residents with enteral feedings were weighed by 9/18/22 by the designated CNA Weights are documented by the nurse manger in Matrix, weights are entered by every Thursday by 5pm.The DON/ADON/Unit Manager will review the weight process the following day and the regional nurse/regional nurse 2 will validate the process. Corporate Resource Nurse(s) reviewed enteral feeding resident weights for significant weight loss and variances on 9/27/22 completed by 5:00pm central time. Follow up reviews will be held by the Administrator and DON every Wednesday at 3:00pm CST with the Resident at Risk Team in the clinical management office. Regional Director of Operations will review Administrator and Don Resident of Risk Team findings for identified concerns and will address immediately and take to QAPI for further follow up. POR will tick and tie the audit tools to validate the POR has been completed and all allegations are investigated and reported timely. All Residents at Risk documentation and action(s) taken will be presented to the QAPI Committee monthly. RN, LPN, C.N.A., and CMA was educated by Corporate Resource Nurse(s) on significant weight loss, interventions, physician/nurse notifications, proper enteral feeding positioning, signs of acute respiratory failure, signs of aspiration pneumonia, and severe sepsis. RN's and LPNs were educated on the proper rate, formula, flushes, entering orders into the electronic medical record, change of condition, to include physician and family notifications. The regional nurse manager education team consisted of seven regional nurse managers, RN. Education was completed with 1-2 staff members at a time. Education is housed in the POR binder. Completed on 10/4/22 5:00 pm Central Time The center does not use agency staff, if the center utilizes agency staff or hires new staff, staff will complete the appropriate education prior to working on the floor. Education will be completed by the Regional Nurse Manager, RN/DON, RN/Nurse manager RN. Completed on 10/4/22 5:00 pm Central Time Please accept our plan of removal and lift the jeopardy effective 10/4/2022 . (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure residents who received enteral feedings were positioned in a manner to prevent aspiration for two (#3 and #9) of three sampled residents who were reviewed with enteral feedings. The Resident Census and Conditions of Residents form identified six residents who received nutrition by tube feeding. Findings: The Enteral Nutrition policy, dated November 2018, read in parts, .Risk of aspiration is assessed by the nurse and provider .Risk of aspiration may be affected by .Improper positioning of the resident during feeding . 1. Resident #3 had diagnoses which included dysphagia and gastrostomy. The Care Plan, dated 08/23/22, documented the resident had a feeding tube and the goal was the resident will experience no complications. A Physician's Order Report, dated 08/01/22 to 09/01/22, documented the resident was to receive Glucerna 1. 2 at 50ml/hr for 20 hours per day. The discharge assessment, dated 09/02/22, documented Resident #3 had a feeding tube. A hospital record, dated 09/02/22 at 7:59 p.m., read in part, .presents from nursing home for concern of possible aspiration. Per report wound care nurse came to see patient around 1800 [6:00 p.m.] he was lying flat with the tube feeding bad [sic] open and finished and patient was hypoxic in the 60's and does not normally wear oxygen . A hospital record, dated 09/02/22 at 8:32 p.m., read in part, .does have very severe rhonchi and wet cough . most likely mucous plug or aspiration pneumonitis . A nurse note, dated 09/03/22 at 6:30 p.m., documented the resident had a change in condition which was noted when the wound care nurse had went into the room to treat his wound. The resident's oxygen saturation was 73%. The oxygen saturation was rechecked after the administration of five liters of oxygen via nasal cannula and was 95%. The resident was sent to the hospital. The note documented the physician and family were notified of the change of condition and was transferred to the hospital at 7:10 p.m. A hospital record, dated 09/05/22, read in part, .RLL pneumonia - suspected aspiration . On 09/13/22 at 10:05 a.m., wound nurse #2 was asked what the resident's position was when they had entered to provide wound care on 09/02/22. They stated the resident was lying flat in bed. They were asked if the resident's enteral feeding was infusing. They stated yes. Wound nurse #2 was asked who was responsible to ensure residents who received enteral feedings were positioned in a manner to prevent aspiration. They stated the charge nurse. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/13/22 at 10:35 a.m., wound nurse #1 was asked what the resident's position was when they had entered the room to provide wound care. The wound nurse stated the resident was supine and they had asked wound nurse #2 if the tube feeding was infusing and wound nurse #2 stated it was infusing and turned it off. Wound nurse #1 stated the resident was lethargic, confused, and had a wet cough. On 09/13/22 at 11:03 a.m., the room of Resident #3 was observed to have signs on the wall next to their bed that read the resident can not be flat in bed, NPO precaution, and the resident must be at least 30 degrees in bed. 2. Resident #9 had diagnoses which included dementia and muscle atrophy. An admission assessment, dated 09/04/22, documented the resident was severely impaired in cognition for daily decision making, weight loss/gain was not experienced or unknown, and they had a feeding tube. A care plan, updated 09/13/22, read in part, .Elevate HOB 30 degrees . On 09/15/22 at 2:50 p.m., Resident #9 was observed lying flat in bed on their left side. The head of the resident's bed was elevated, however, the resident was positioned in the fetal position in the middle/end of the bed. The enteral feeding was observed to be infusing at 40cc/hr. Resident #9's room was across from the nurses desk and the door to the room was open. On 09/15/22 at 2:55 p.m., CNA #1 was observed to enter the resident's room and asked if the resident was okay. RNM #2 looked into the resident's room. The resident did not answer and the CNA exited the room. On 09/15/22 at 2:58 p.m., RNM #2 entered the room, observed the enteral feeding pump, and exited the room. On 09/15/22 at 3:04 p.m., RNM #2 entered the resident's room and exited after a few seconds. On 09/15/22 at 3:10 p.m., ADON #1 and CNA #1 entered the resident's room. ADON #1 stated they were going to provide oral care and reposition the resident higher in bed. ADON #1 exited the room to obtain gloves. On 09/15/22 at 3:12 p.m., RNM #2 looked into the resident's room. The resident was observed to be lying flat in their bed and the enteral feeding was observed to infuse at 40cc/hr. On 09/15/22 at 3:15 p.m., ADON #1 was observed to provide oral care. The resident was observed to be lying flat in their bed with the tube feeding infusing. On 09/15/22 at 3:19 p.m., CNA #1 entered the resident's room with a mechanical lift and joined ADON #1. CNA #1 raised the bed up higher. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/15/22 at 3:22 p.m., CNA #1, ADON #1, CNA #2, CNA #3, and Regional Nurse Manager #2 were in the resident's room. ADON #1 had removed a loose dressing from the resident's sacral area. The resident was observed to have had a bowel movement and ADON #1 and CNA #1 positioned the resident slightly more toward the head of the bed and began providing incontinent care. The resident was observed to continue to lie flat with the enteral tube feeding infusing. Regional Nurse Manager #2 exited the room. On 09/15/22 at 3:27 p.m., ADON #1 was asked at what angle the resident was positioned. They stated, Maybe 15-20 degrees. CNA #1 lowered the head of the bed until it was flat. The resident continued to lie flat in bed. On 09/15/22 at 3:36 p.m., the incontinent care and bedding change was completed. The resident was observed to be supine during the care. The enteral feeding pump was observed to be on hold at this time. CNA #1 and CNA #2 were observed to stand by the enteral feeding pump. ADON #1 was observed to be on the opposite of the bed from the enteral feeding pump since 3:15 p.m. On 09/15/22 at 3:39 p.m., ADON #1 exited the room and CNA #1 was asked who put the enteral feeding pump on hold. They stated they had just placed the pump on hold. They were asked why they had placed the enteral feeding pump on hold. They stated they knew it was supposed to be on hold due to the position of the resident. On 09/15/22 at 3:49 p.m., CNA #1, CNA #2, and CNA #3 had completed resident care and positioned the resident at a 30 degree angle in bed. On 09/15/22 at 4:09 p.m., ADON #1 was asked how resident's who received continuous enteral nutrition were to be positioned. They stated their head was to be elevated 30 degrees. They were asked why they were to be positioned at a 30 degree angle. They stated to prevent aspiration pneumonia. ADON #1 was asked why Resident #9 was not positioned in a manner to prevent aspiration pneumonia. They stated they had observed the angle of the head of the bed. They stated they did not look at the resident's position. The ADON #1 was asked why the enteral feeding was not held during the provision of care until 3:36 p.m. They stated they told CNA #1 to place the pump on hold. They were asked if a 15-20 degree angle was sufficient to prevent aspiration. They stated no. On 09/16/22 at 12:20 p.m., the resident was observed in bed with the enteral feeding infusing at 40cc/hr. The resident's torso was observed to be angled at approximately ten degrees. On 09/16/22 at 12:25 p.m., LPN #2 was asked what position the resident was to be in to prevent aspiration when the enteral feeding was infusing. They stated the resident's head needed to be elevated and the resident was to be kept comfortable. They were asked when the last time they had assessed Resident #9. They stated approximately 30 minutes ago. They were asked at what angle the resident was positioned. They observed the resident and stated, Not quite high enough, I'm not good on numbers. Not very much, not even ten degrees. LPN #2 was asked why the resident was not positioned in a manner to prevent aspiration. They stated they had the resident a little higher earlier. They were asked at what angle had they positioned the resident. LPN #2 stated, I don't know. I'm not good at degree numbers. On 09/16/22 at 12:27 p.m., LPN #2 walked down the hall to pass meal trays. They did not reposition the resident. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/16/22 at 12:34 p.m., RNM #1 and RNM #3 were asked what angle residents who received enteral feedings were to be placed to prevent aspiration. RNM #1 stated 30 degrees. They were asked what angle Resident #9 was positioned. They observed the resident and RNM #3 stated approximately ten degrees. RNM #1 and RNM #3 were informed of the observations of the resident not positioned to prevent aspiration and was asked why the resident was not positioned in a manner to prevent aspiration. RNM #1 stated the staff were not paying attention. On 09/24/22 at 8:44 a.m., CNA #5 was asked what angle the resident needed to be to prevent aspiration. CNA #5 stated 90 degrees. They were asked what position the resident was currently in. They stated about 30 degrees. On 09/24/22 at 8:46 a.m., Resident #9 was observed lying in bed at approximately a 15 degree angle. RNM #3 was asked at what angle the resident was positioned. They stated approximately 20 degrees. They stated the resident at times would slide down in bed and if they elevated the foot of the bed that may help with positioning. RNM #3 stated they were going to check the resident's orders. On 09/24/22 at 9:08 a.m., RNM #3 and the DON entered the resident's room and repositioned the resident. The DON was asked what angle the resident was to be positioned to prevent aspiration. They stated 30 degrees. 41809

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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. 35474 Based on record review and interview, the facility failed to ensure medications were available for three (#4, 10 and #14) of three sampled residents who were reviewed for medication availability. RNM #1 identified 100 residents who received medications in the facility. Findings: 1. Resident #10 had diagnoses which included hypercholesterolemia. The Medication Administration Record, dated 09/01/22 through 09/13/22, documented Atorvastatin (a cholesterol medication) 40mg at 7:00 p.m. on 09/09/22 and 09/10/22, Metronidazole (an antibiotic) 500mg at 3:00 p.m. and 7:00 p.m. on 09/10/22, and Sodium Bicarb 650mg at 3:00 p.m. were not available for administration. 2. Resident #4 had diagnoses which included pruritus and atherosclerotic heart disease. The Medication Administration Record, dated 09/01/22 through 09/19/22, documented Atorvastatin 80mg at 7:00 a.m. on 09/10/22 and Hydroxyzine (an antihistamine medication) 50mg at bed time on 09/11/22 were not available for administration. 3. Resident #14 had diagnoses which included depression, neuropathy, and chronic pain. The Medication Administration Record, dated 09/01/22 through 09/22/22, documented Biofreeze (a topical analgesic) 5% at 7:00 a.m. on 09/11/22, Gabapentin (an anticonvulsant medication) 300mg at 7:00 p.m. on 09/09/22, and Sertraline (an antidepressant medication) 200mg at 7:00 a.m. on 09/20/22 and 09/21/22 were not available for administration. The area to document administration of the Sertraline for 09/19/22 and 09/22/22 was left blank. On 09/22/22 at 12:25 p.m., the DON was asked who was responsible to ensure medications were available for administration. They stated the nurses or the DON. They were asked how medication availability was monitored. The DON stated the medication cards had an indicator on the side which indicated the medication quantity was low. The DON was asked what type of oversight and monitoring they had provided to ensure residents' medications were available. They stated they monitored frequently along with the charge nurses. The DON stated they monitored the narcotic counts but was not sure how the facility monitored medications for all residents. The DON was asked how the charge nurses monitored medication availability. They stated the nurses were to monitor the medication administration records at the end of their shift to ensure medications were available for administration. The DON was asked why medications were not available for administration. The DON stated they did not know. They were asked if effective monitoring had been provided to ensure medications were available for administration. The DON stated they had not noticed any medications were not available for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/22/22 at 12:46 p.m., RNM #1 was asked who was responsible to ensure medications were available for administration. They stated the DON and the ADON were to monitor and print compliance reports. They were asked if effective monitoring had been provided to ensure medications were available for administration. They stated the regional nurses were going to start monitoring and support the clinical staff to correct what was not working with medication availability. On 09/30/22 at 12:10 p.m., CMA #1 was asked about the Sertraline for Resident #14. They stated the Sertraline had not been administered on 09/19/22 through 09/30/22 because the medication was unavailable. The CMA stated they had ordered the medication on 09/16/22 and again on 09/29/22. They stated they had notified LPN #1 the medication was reordered from the pharmacy on 09/16/22. 41809

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35474 Based on observation, record review, and interview, the facility failed to ensure foods were served at palatable temperatures for one (noon meal) of one meal observed for palatability. The RNM #1 identified 98 residents who received food from the kitchen. Findings: A Food and Nutrition Services policy, dated September 2021, read in parts, .Food and nutrition services staff will inspect food trays to ensure .the food appears palatable and attractive, and it is served at a safe and appetizing temperature . On 09/14/22 at 1:21 p.m., Resident #14 stated their meals were often cold. On 09/19/22 at 12:21 p.m., Resident #8 stated their meals were cold. On 09/20/22 at 1:15 p.m., a sample tray was the last meal tray on the hall cart and was provided to the surveyors. The ham, carrots, and the roll were slightly warm to touch and the plate was room temperature. On 09/21/22 at 10:51 a.m., the dietary manager was informed the noon meal sample tray was not hot. They were asked what the facility had implemented to ensure foods were served at palatable temperatures. The dietary manager stated they had ordered hot carts, used lids on the plates, and had a warmer for the plates. They stated the plate warmer was not working. The dietary manager stated they used open towers to deliver the hall trays. The dietary manager was asked if they monitored food temperatures. They stated yes. The dietary manager was asked if they had the equipment needed to serve hot foods hot. The dietary manager stated no. On 09/21/22 at 1:00 p.m., the dietary manager stated they were mistaken and hot carts had not been ordered for the facility to deliver the hall trays. On 09/22/22 at 4:52 p.m., Resident #1 stated hot foods were served cold. 41809

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	10/04/2022

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 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35474 Based on observation, record review, and interview, the facility failed to ensure effective administration to prevent multiple system failures. The Resident Census and Conditions of Residents form identified 100 residents who resided in the facility. Findings: a. ensure resident funds were conveyed within 30 days of death; b. ensure a homelike environment; c. ensure residents were free from abuse; d. ensure the abuse policy was implemented; e. ensure an abuse allegation was reported; f. ensure medications and treatments were administered per the physicians' orders; g. identify pressure ulcers, ensure pressure ulcers did not worsen, ensure physician notification was made and documented, admission skin assessments were conducted, identify the signs of wound infections, and ensure wound treatments were provided; h. ensure a resident did not experience severe weight loss; i. ensure residents who received enteral nutrition were positioned in a manner to prevent aspiration; j. ensure medications were available; k. ensure meals were served at palatable temperatures; and l. ensure care concerns were identified, and good faith attempts were made to correct identified issues through the QA/QAPI program. On 09/21/22 at 3:21 p.m., RNM #1 was asked who was responsible to monitor to ensure quality of care concerns were identified and corrected. They stated RNMs, DON, and ADONs. RNM #1 was asked why QA/QAPI plans had not been effective. They stated once a concern had been corrected, the care area was removed from the list of concerns. RNM #1 was asked if administration would have been aware of quality of care concerns identified by the survey team if effective monitoring was in place. They stated yes. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 09/21/22 at 4:55 p.m., RNM #1 was asked what type of oversight had been provided for quality of care concerns. RNM #1 stated they could not say effective oversight had been provided. 41809

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F 0837 Level of Harm - Actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 35474 Based on record review and interview, the facility failed to ensure an effective governing body which was involved and engaged during a time of instability of staff in administrative roles. The Resident Census and Conditions of Residents form identified 100 residents resided in the facility. Findings: A Quality Assurance and Performance Improvement Program policy, dated August 2019, read in parts, . Quality Assurance and Performance Improvement is a continuous process towards quality management . Quality Assurance and Performance Improvement [QAPI] builds upon traditional quality assurance methods by emphasizing the organization and systems. QAPI incorporates systems, programs, clinical practice, and clinical development driving system integrations and inter-program coordination through organized leadership oversight .The QAPI Committee provides leadership and guidance for ongoing continuous quality and performance improvement .QAPI is facilitated through leadership oversight . A Quality Assurance and Performance Improvement [QAPI] Program - Governance and Leadership policy, dated March 2020, read in parts, .The governing body is responsible for ensuring that the QAPI program: Is implemented and maintained to address identified priorities .Is sustained through transitions of leadership and staffing . A Governing Body policy, dated July 2021, read in part, .The governing body is responsible and accountable for the QAPI program . The facility had deficient practice cited in regards to pharmacy services on the survey dated 07/13/22 and the survey dated 08/04/22. The facility was unable to correct this deficient practice by the correction dates the facility identified on the plan of corrections. The facility had deficient practice cited in regards to abuse/neglect, pressure ulcers, homelike environment, and palatable food on the survey dated 08/04/22. The facility was unable to correct these deficient practices by the correction dates the facility identified on the plan of corrections. The facility had deficient practice in regards to abuse/neglect, implementation of the abuse policy, reporting of abuse, pressure ulcers, significant weight loss, and tube feeding at the level of Immediate Jeopardy during the current survey. On 09/15/22, an IJ situation was identified and verified in pressure ulcers. On 09/16/22, IJ situations were identified and verified in significant weight loss and tube feeding. On 09/28/22, IJ situations were identified and verified in abuse/neglect, implementation of the abuse policy, and reporting abuse. By the survey exit on 10/04/22 at 1:00 p.m., the IJ situations continued at a level of Immediate Jeopardy until 10/04/22 at 5:00 p.m. (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Some	On 09/21/22 at 3:49 p.m., the Regional Director of Operations was asked how long they had been employed by the facility. They stated approximately one month. They stated they were in a newly identified position. The Regional Director of Operations was asked if they had identified concerns related to pressure ulcers, significant weight loss, or tube feedings. They stated when they first started the facility had new staff in leadership positions. The Regional Director of Operations stated they barely had clinical morning meetings and they had to start with the basics. On 09/21/22 at 4:55 p.m., RNM #1 was asked what type of oversight had been provided for quality of care concerns. They stated they could not say effective oversight had been provided. On 09/22/22, the Regional Director of Operations provided the survey team a list of members of the governing body as requested. The list identified the governing body consisted of the Regional [NAME] President/Regional Director of Operations, the medical director, and the CEO. 41809

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F 0867 Level of Harm - Actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35474 Based on record review and interview, the facility failed to ensure an effective QA/QAPI program to correct identified quality deficiencies. The Resident Census and Conditions of Residents form identified 100 residents resided in the facility. Findings: A Quality Assurance and Performance Improvement Program policy, dated August 2019, read in parts, . Quality Assurance and Performance Improvement is a continuous process towards quality management . Quality Assurance and Performance Improvement [QAPI] builds upon traditional quality assurance methods by emphasizing the organization and systems. QAPI incorporates systems, programs, clinical practice, and clinical development driving system integrations and inter-program coordination through organized leadership oversight .The QAPI Committee provides leadership and guidance for ongoing continuous quality and performance improvement .QAPI is facilitated through leadership oversight . The facility had deficient practice cited in regards to pharmacy services on the survey dated 07/13/22 and the survey dated 08/04/22. The facility was unable to correct this deficient practice by the correction dates the facility identified on the plan of corrections. The facility had deficient practice cited in regards to abuse/neglect, pressure ulcers, homelike environment, and palatable food on the survey dated 08/04/22. The facility was unable to correct these deficient practices by the correction date the facility identified on the plan of correction. The facility had deficient practice in regards to abuse/neglect, implementation of the abuse policy, reporting of abuse, pressure ulcers, significant weight loss, and tube feeding at the level of Immediate Jeopardy during the current survey. On 09/15/22, an IJ situation was identified and verified in pressure ulcers. On 09/16/22, IJ situations were identified and verified in significant weight loss and tube feeding. On 09/28/22, IJ situations were identified and verified in abuse/neglect, implementation of the abuse policy, and reporting abuse. By the survey exit on 10/04/22 at 1:00 p.m., the IJ situations continued at a level of Immediate Jeopardy until 10/04/22 at 5:00 p.m. On 09/21/22 at 2:03 p.m., the medical director was asked how they were involved to ensure appropriate plans and interventions to prevent repeated system failures were implemented. They stated they could not speak to things that had not been brought to their attention. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	On 09/21/22 at 3:21 p.m., RNM #1 was asked how often QA meetings were conducted. They stated monthly. RNM #1 was asked what the facility had implemented to provide a good faith attempt to correct identified deficiencies. They stated they used their QAPI program, quality measure reports, and every department reviewed the QAPI plan. RNM #1 was asked who was responsible to monitor to ensure quality of care concerns were identified and corrected. They stated regional nurse managers, DON, and ADONs. RNM #1 was asked if prior to the survey if the QA/QAPI committee had identified quality deficiencies. They stated they identified concerns with wounds and weight loss. RNM #1 was asked how they monitored for effective corrective actions for wounds and weight loss. RNM #1 stated they joined the treatment nurses during wound care rounds and reviewed reports during clinical meetings. They were asked if the QA/QAPI plans had been effective. RNM #1 stated no. RNM #1 was asked why the QA/QAPI plans had not been effective. They stated once a concern had been corrected the care area was removed from the list of concerns.