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	11/15/2022

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 11/10/22 at 10:07 p.m., an immediate jeopardy (IJ) was identified and verified by the Oklahoma State Department of Health (OSDH). The facility failed to implement their infection control policy and procedure to ensure residents were protected from the transmission and spread of a communicable disease. The facility failed to cohort residents with the same test result; don appropriate PPE when entering an airborne isolation precaution room; ensure employees were properly trained to administer COVID-19 testing; and effectively track, trend, and educate staff with the results of COVID-19 testing for positive and negative residents. This system failure increased the risk of severe illness or death. On 11/10/22, the facility was notified and a plan of removal (POR) was requested on 11/10/22 at 10:24 p.m. By the survey exit date of 11/15/22 at 4:30 p.m., an acceptable plan of removal had not been received. The immediacy remains. Based on record review, observation, and interview, the facility failed to: a. implement and maintain an effective infection control program to ensure residents were protected from the transmission and spread of a communicable disease; b. cohort residents with the same COVID-19 status in the same room; c. don appropriate PPE when entering an airborne isolation precaution room; and d. ensure employee was properly trained to administer a COVID-19 test and effectively track, trend, and educate staff with the results of COVID-19 positive and negative residents for one of one employee files reviewed for education. The Resident Census and Conditions of Residents form documented 76 residents resided in the facility. Findings: (continued on next page)

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

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents policy, revised September 2021, read in part, .Residents with signs and symptoms of COVID-19 are identified and isolated to help control the spread of infection to other residents, staff and visitors .A COVID-19 care unit (which may be a dedicated floor, unit, wing or cluster of rooms at the end of a hallway) has been established to cohort and manage the care of residents with confirmed SARS-CoV-2 infection .Residents who are close contacts 1. Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection are placed in quarantine for 14 days after their exposure, even if viral testing is negative. Staff caring for them use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). 2. Fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection wear source control and are tested . The CDC Infection Control Guidance, updated Sept. 23, 2022, read in parts, .Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection .The IPC recommendations described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing . A. Review of the facility's undated Matrixcare Infection Tracker revealed resident #5 and resident #6 roomed together and tested positive for COVID-19 on different dates; resident #3 and resident #4 roomed together and tested positive on different dates; resident #10 and resident #11 roomed together and resident #10 had tested positive for COVID-19 while resident #11 had tested negative. The tracker documented the following: Resident #6 tested positive for COVID-19 on 11/01/22 and remained in room SE85 with a non-COVID-19 positive roommate, Resident #5. Resident #6's projected end date for isolation was 11/11/22. Resident #5 tested positive for COVID-19 on 11/04/22 and remained in room SE85 with a COVID-19 positive roommate, Resident #6. Resident #5's projected end date for isolation was 11/14/22. Resident #3 tested positive for COVID-19 on 10/24/22 and remained in room SE80 with a non-COVID-19 positive roommate, Resident #4. Resident #3's projected end date for isolation was 11/04/22. Resident #4 tested positive for COVID-19 on 11/01/22 and remained in room SE80 with a COVID-19 positive roommate, Resident #3. Resident #4's projected end date for isolation was 11/11/22. Resident #10 rested positive for COVID-19 on 11/01/22 and remained in room SE71 with a non-COVID-19 roommate, Resident #11. Resident #10's projected end of isolation date was 11/11/22. Resident #11 tested negative for COVID-19 on 10/18/22, 10/21/22, 10/25/22, 10/28/22, 11/01/22, 11/04/22, and 11/08/22 but remained in room SE71 with a COVID positive roommate, Resident #10. The infection tracker identified 10 residents who were positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/12/22 at 9:22 a.m., during State monitoring, CNA #3 was asked if COVID-19 positive and COVID-19 negative residents were roomed together. They stated yes, the residents in room SE85 had continued in the same room even though Resident #6 tested positive for COVID-19 on 11/01/22 and their roommate, Resident #5, remained negative until 11/04/22. On 11/13/22 at 9:33 a.m., during monitoring, CNA #10 stated to the surveyor that Resident #5 had passed away, and was found without vital signs at 9:10 a.m. Resident #5 hospice nurse note, dated 11/02/22 at 10:08 a.m., read in parts, .This patient on service for primary diagnosis of malignant neoplasm of esophagus. PT's[patient's] room mate has covid and facility will not quarantine .V/S B/P 93/60, P-83, R-18, T-97.4 . Resident #5 hospice nurse note, dated 11/02/22 at 2:04 p.m., read in parts, .PRN visit made for weakness . PT [patient] stated he stays in bed away from everyone because he does not want to get covid . B. On 11/09/22 at 4:15 p.m. resident #3 was observed in the southeast hall, near the entrance to the isolation room for resident #4 who was positive for COVID-19. LPN #1 stated Resident #3 also resided in the room with Resident #4. Resident #3 did not have a mask or any other PPE on and no staff were observed to ask the resident to don a mask or PPE or instruct the resident in the need for / use of PPE. On 11/09/22 at 4:15 p.m., LPN #1 was observed to have facial hair which was composed of a mustache and long beard. LPN #1 was observed to wear a surgical mask, don a gown and gloves and enter the isolation room for resident #4 who was positive for COVID-19. LPN #1 did not don an N95 mask nor a face shield. On 11/09/22 at 4:15 p.m., LPN #1 was asked if resident #3 was in isolation. They stated no. On 11/09/22 at 4:15 p.m., LPN #1 pointed to room [ROOM NUMBER] and stated there was another room where one resident had tested positive and the other resident continued to test negative and had not been moved from room [ROOM NUMBER]. LPN #1 stated resident #10 tested COVID-19 positive on 11/01/22 and their roommate, Resident #11 (tested COVID-19 negative) would come and go from the isolation room. On 11/09/22 at 4:28 p.m., Resident #3 was observed to wander into room SE75, an isolation room. CMA #1 was observed to enter the room wearing an N95 mask and gloves, and assist the resident back out of the room. CMA #1 did not wear a gown or face shield. On 11/09/22 at 4:30 p.m., CMA #1 was observed to sanitize their hands and don gloves and gown before entering the same isolation room at the end of the hall to provide the resident with medications. CMA #1 did not wear a face shield. On 11/09/22 at 7:25 p.m., CMA #1 wore an N95 mask and was observed to don gloves and gown. CMA #1 did not wear a face shield when they entered the room. CMA #1 stated resident #3 was asleep in bed A. CMA #1 stated resident #4 (COVID-19 positive resident) was in bed B. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/09/22 at 10:45 p.m., CNA #1 was observed to wear a surgical mask, face shield, gloves, and gown to enter room SE85. The Resident #3 in SE85A was resting in bed with their eyes closed. CNA #1 was observed in a COVID-19 positive room with a surgical mask on. On 11/09/22 at 11:40 p.m., the DON was asked why Resident #3, (a non-COVID-19 positive resident and wanderer), resided in the same room as Resident #4, (a COVID-19 positive resident) in isolation. The DON looked at the resident roster and stated Resident #3 did not reside in the room with Resident #4. The DON was asked to confirm Resident #3 was not in the room with Resident #4. The DON was observed to don an N95 mask, gloves, and gown before entering the isolation room for Resident #4 (a COVID-19 positive resident). The DON did not wear a faceshield or goggles. The DON stared at both beds occupied by Resident #3 and Resident #4 before doffing the PPE and exiting the room. The DON asked ADON #3 why Resident #3 (a non-COVID-19 positive resident) was not in the room listed on the room roster. ADON #3 stated the resident had never been in the room listed on the room roster. On 11/09/22, the room roster documentation reflected Resident #3 (a non-COVID-19 positive resident) was residing in room SE76B. Resident #3 was observed asleep in room SE80A throughout the evening hours and night. On 11/10/22 at 11:55 p.m., four of the six isolation carts on the southeast hall were observed to not have face shields. The DON was asked why there were no face shields on four of the six isolation carts. The DON entered the southeast hall and checked the availability of face shields, finding faceshields in an isolation cart at the beginning of the hall, near the nurses' station and at the very end of the hall but none in the four other isolation carts located in between. The DON stated they just had not been restocked. The DON was observed to look in the southeast office, and a few of the storage rooms for face shields. The DON stated they knew there was a box of face shields somewhere but did not know where they were located. On 11/10/22 at 12:15 a.m., corporate consultant #1 stated they needed to see for themselves who resided with Resident #10 (a COVID-19 positive resident). The corporate consultant was wearing only a surgical mask and walked down the hall to the resident's room. Without donning any more PPE, the corporate consultant entered the isolation room for Resident #10 and stared at the occupied beds. The corporate consultant exited the room and was asked why they had not donned PPE. The corporate consultant stated they were just entering the room to look at the resident and not provide care. The corporate consultant was asked when they expected their nursing staff to don PPE. The corporate consultant stated the staff were to don PPE prior to entering the resident's room. The corporate consultant stated they understood what the surveyor was intending with the question but reiterated they had just stepped in for a minute to identify who each resident was in the room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/10/22 at 12:15 a.m., the corporate consultant stated Resident #11 had tested COVID-19 positive on 11/04/22. The corporate consultant stated the COVID-19 negative result documented for 11/04/22 was in error. The corporate consultant stated they remembered the testing because the resident had left the facility alone and tested positive when they returned. The corporate consultant #1 was asked if the resident tested positive on 11/04/22, why were they tested negative again on 11/08/22. They stated the person entering the batch testing results simply forgot to unclick the resident's name before saving the results. The corporate consultant was asked if the testing results were documented in error twice, how did the facility ensure the other documented testing results were accurate. The corporate consultant asked if the surveyor wanted the facility to test the residents now. The surveyor responded that it was after midnight and most residents were asleep. The corporate consultant stated it would not take long to test the roughly 19 residents left who had not tested COVID-19 positive in the last 90 days. On 11/10/22 at 2:20 a.m., ADON #3 stated Resident #3 tested negative for COVID-19 at 2:10 a.m.; Resident #4 tested negative for COVID-19 at 2:14 a.m.; and Resident #11 tested negative for COVID-19 at 2:15 a.m. On 11/10/22 at 2:25 a.m., ADON #3 was observed to wear an N95 mask over medium length facial hair. The ADON was observed to walk down the SE hall and enter an isolation room (SE71) without donning any further PPE. The ADON was observed to exit the room shortly after, carrying a culture swab for COVID-19 testing in their ungloved hand. The ADON stated they had tested Resident #10. The ADON entered an office on the southeast hall and applied the culture swab to the testing card before adding approximately five drops of reagent. The ADON was asked how long before the test was complete. They stated the results were immediate and could be read as soon as the reagent was observed to cover the sponge/testing window. In less than two minutes, ADON #3 stated the resident tested negative. Review of the BinaxNOW COVID-19 AG product insert documented to read results in the window 15 minutes after closing the card. On 11/10/22 at 2:45 a.m., the DON was asked what the facility policy was regarding PPE when entering a COVID-19 positive room. The DON stated the staff should don gloves, gown, mask, and face shield. The DON was asked to clarify what type of mask to wear when entering a COVID-19 positive room. The DON stated the staff were to wear an N95 mask. The DON was asked why the staff were observed to wear surgical masks when entering a COVID-19 positive isolation room. The DON stated the staff should be wearing N95 masks. The DON was asked if an N95 was effective for someone with facial hair. The DON stated the nurse was to have shaved. The DON was asked why LPN #1 was assigned to a hall with COVID-19 positive residents when the LPN had obvious facial hair. The DON stated they did not know who made the assignments. The DON was asked who monitored to ensure the staff were wearing appropriate PPE and the necessary PPE was available for use. The DON stated the Infection Preventionist was responsible to monitor staff to ensure proper use of PPE and check the isolation carts for adequate PPE supplies. The DON was asked why the observations of improper use of PPE and a limited availability of supplies. The DON stated they did not know. Review of the facility's Matrix for Providers form, received on 11/10/22, documented no residents with an infection of COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/10/22 at 1:21 p.m., observations were made of Resident #4, who was COVID-19 positive, and Resident #3, who was COVID-19 negative, resided in the same room. LPN #1 was observed to don gloves and a gown to enter the resident's room. LPN #1 did not don an N95 mask or face shield/goggles. Signs on the resident's door indicated droplet transmission based precautions. C. On 11/10/22 at 4:32 p.m., the IP was asked what the facility's testing policies/protocols were. They stated they had not seen the policies. The IP was asked if they had been trained to perform the test. They stated yes they had been trained at a previous facility by an RN but not at this facility. The IP was asked what PPE was required to be worn when the COVID-19 test was administered. They stated gloves and a surgical mask or an N95. The IP was asked if they had been fit tested for an N95. They stated no. The IP was asked if they knew the CDC guidance for the COVID-19 testing procedure. They stated they had in the past but did not anymore. The IP was asked if they knew where to find the information. They stated no. The IP was asked if they had performed COVID-19 tests at the facility. They stated yes, on 11/08/22, and was scheduled to perform the tests again on 11/11/22. The IP was asked how they determined who required testing. They stated from a list of who had not tested positive in the last 90 days located on a white board in the office. The IP was asked what PPE was required to enter a resident's room that was positive for COVID-19. They stated gloves, face shield, gown, and an N95 mask or surgical mask if fully vaccinated. On 11/10/22 at 5:28 p.m., the DON was asked who administered COVID-19 tests in the facility. They stated the IP nurse, a medical records employee, and others could assist with prep and setup of the test. The DON was asked who had been trained to administer COVID-19 tests. The DON stated the IP and the medical records employee. The DON was asked who provided the training for the medical records employee. They stated they did not know, the training had been completed prior to the DON's employment at the facility. The DON was asked if they had observed the medical records employee administer the test. They stated yes, the medical records employee had tested the DON for COVID-19. The DON was asked how the facility cohorted residents. They stated positive with positive and negative with negative. On 11/10/22 at 7:44 p.m., CMA #1 was asked if they had been tested for COVID-19 at the facility. They stated yes by the IP on 11/04/22. CMA #1 stated the IP allowed them to self test. CMA #1 was asked what they meant by self test. CMA #1 stated they were able to test themselves for COVID-19. CMA #1 was asked if they had knowledge of positive and negative residents housed in the same room. They stated yes, they treated both as if they were positive and wore full PPE when they entered their room. The CMA was asked what she considered full PPE. She stated gloves, gown, N95 mask, and face shield. CMA #1 was asked if they felt the facility administered proper infection, prevention, and control practices. Review of the facility's [NAME] BinaxNOW COVID-19 Ag Card - Training Checklist, for the medical records employee revealed the checklist was dated and signed by the IP on 08/16/22. The checklist did not provide documentation which indicated that the IP had completed the training and had competently performed specimen collection, storage, and handling or sample preparation, test procedure for quality control and patient testing. The facility did not provide a training checklist for the current IP.