STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375496	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing and Rehabilitation	800 Arapaho Avenue Hydro, OK 73048

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, record review, and interview, the facility failed to develop a policy to assess a resident's capacity to consent to sexual contact for 2 (#1 and #2) of 4 residents reviewed for consent of sexual relations. The DON reported 37 residents resided in the facility. Findings: The administrator reported the facility did not have a policy for assessment of residents to determine sexual consent. 1. On 05/15/25 at 11:35 a.m., Resident #1 was interviewed in their room. While talking with the resident, Resident #2 was observed to ambulate down the hall outside Resident #1's room. A quarterly assessment, dated 04/22/25, showed Resident #1 was severely cognitively impaired with a BIMS score of 03. The assessment showed the resident was independent with activities of daily living. The assessment showed the resident had diagnoses which included altered mental status, mood disorder, depression, osteoarthritis, Alzheimer's disease, and vascular dementia. A progress note, dated 05/11/25 at 3:17 p.m., showed a CNA reported Resident #1 was observed to wander into Resident #2's room. The note showed when the CNA went to redirect the resident, the CNA observed Resident #2 grab Resident #1 in their vaginal area over their clothes as the resident was walking away. The note showed the residents were separated and Resident #1 was redirected to their room and assessed. A care plan, dated 05/13/25, showed an incident on 03/10/25 in which Resident #1 was observed kissing Resident #2 by a housekeeper. The care plan showed the residents were easily redirected and hourly checks for 48 hours were initiated. The care plan showed on 05/11/25, Resident #1 wandered into Resident #2 room. The care plan showed Resident #2 grabbed Resident #1 in the vaginal area. The care plan showed Resident #1 was redirected to their room, the resident was assessed, and hourly checks were initiated. On 05/15/25 at 11:38 a.m., Resident #1 was asked if they knew Resident #2. Resident #1 stated yes, and reported Resident #2 was their friend. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 12:30 p.m., the DON reported Resident #1 and Resident #2 had been together at another facility prior to being admitted to this facility. The DON reported the two residents rode together in the same van when transferred to this facility and were very familiar with each other. The DON reported Resident #1 would seek out Resident #2 and had been observed to hold hands and sit together. On 05/15/25 at 1:12 p.m., Resident #1's family member was interviewed by phone. The family member reported no complaints related to the resident's care and reported they felt their loved one was safe at the facility. The family member reported the facility notified them immediately when the incident happened with Resident #2. On 05/15/25 at 2:20 p.m., CNA #1 reported they were not aware of Resident #2 having any behaviors toward any other resident. The CNA reported Resident #1 seeks out Resident #2 and they have heard Resident #2 tell Resident #1 to leave their room. On 05/15/25 at 4:18 p.m., CNA #2 reported Resident #2 was alert and oriented, knew what they were doing, but Resident #1 was known to seek out Resident #2. The CNA reported if they observed Resident #1 going down the hall, they assumed the resident was going to Resident #2's room, so they immediately redirected the resident. The CNA reported the situation had been better since Resident #1 was moved to a different room further down the hall. 2. A quarterly assessment, dated 04/22/25, showed Resident #2 had diagnoses which included depression, hypertension, mental disorder, amnesia, and insomnia. The assessment showed the resident was cognitively intact with a BIMS score of 15. A care plan, dated 05/14/25, showed an incident on 03/10/25 in which Resident #2 was observed kissing [Resident #1] that had entered the resident's room. The care plan showed the residents were easily redirected and every one-hour checks were initiated for 48 hours. The care plan showed a second incident on 05/11/25 in which Resident #2 was observed to grab[Resident #1] in the vaginal area, while the resident was fully clothed. Hourly checks were initiated for 24 hours. The care plan showed Resident #2 apologized for their behavior and reported it would not happen again. On 05/15/25 at 2:35 p.m., Resident #2 reported Resident #1 used to come to their room a lot before they moved Resident #1 down the hall. Resident #2 stated, I don't want no trouble. The resident went on to say they previously sat at the same dining table with Resident #1 but had recently started sitting at a different table across the dining room. The resident reported they had been at the same facility with Resident #1 before coming to this facility and had known each other a long time. On 05/15/25 at 2:55 p.m., the administrator reported they had interviewed other residents following the incident with Resident #1 and Resident #2. The administrator reported no residents reported an issue with Resident #2 and the resident had no history of being interested in anyone other than Resident #1. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/25 at 9:14 a.m., CNA #3 reported they witnessed the incident with Resident #1 and Resident #2 on 05/11/25. The CNA reported they were walking down the hall past Resident #2's room when they noticed Resident #1 in the room. The CNA reported they went to redirect Resident #1 and walked the resident out of the room when Resident #2 reached underneath the bedside table and touched Resident #1's vaginal area. The CNA reported they told Resident #2 they should not do that, then reported the incident to the charge nurse. The CNA reported Resident #1 was easily redirected and reported Resident #2 wasn't upset but stated they did not do anything wrong. The CNA reported Resident #2 later went to the charge nurse, apologized, and reported they wouldn't do it again. On 05/16/25 at 9:30 a.m., the administrator reported the facility had no policy or assessment tool to determine a resident's ability to consent to sexual activity. The administrator reported they would normally refer to the resident's BIMS score. The administrator reported this was the first situation in which the couple was not married, with a previous consenting relationship, but they could see the need for this type of assessment in residents who show an interest in sexual activity.