STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375515	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Healthcare and Rehab	12 East Conner Fairland, OK 74343

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure residents were educated and offered the opportunity to create advance directive for two (#21 and #23) of 17 sampled residents reviewed for advance directives. A Detail Census Report, dated 12/30/24, documented 24 residents resided at the facility. Findings: 1. Resident #21 was admitted to the facility on [DATE]. A review of Resident #21's electronic health records found no advance directive. 2. Resident #23 was admitted to the facility on [DATE]. A review of Resident #23's electronic health records found no advance directive. On 12/30/24 at 12:00 p.m., Resident #23's representative stated they did not recall talking to the facility staff about advance directives. On 12/31/24 at 8:17 a.m., Resident #21 stated they were unaware of speaking to a staff member about advance directives. On 01/02/25 at 10:21 a.m., the MDS coordinator stated they had not been documenting they offered and educated residents regarding advance directives. They stated there was no documentation in Resident #21 or Resident #23's records of their desire to create an advance directive or if the resident or their POA had declined. They stated they were unaware of when or how often they were supposed to attempt to offer and educate residents about advance directives.

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 42171 Based on record review and interview, the facility failed to ensure a significant change assessment was completed after a resident was admitted to hospice for one (#26) of one sampled resident reviewed for hospice. The DON reported the census was 24. Findings: Resident #24 had diagnoses which included parkinsonism and hypertension. A verbal order form, dated 09/11/24, documented Resident #24 was admitted to hospice on 09/11/24. The resident's medical record was reviewed and did not document a significant change assessment had been completed. On 12/31/24 at 10:11 a.m., the corporate nurse stated a significant change assessment should have been completed within 14 days of the resident being admitted to hospice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42171 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for one (#26) of 17 sampled residents whose care plans were reviewed. The DON reported the census was 24. Findings: Resident #26 had diagnoses which included parkinsonism and hypertension. A verbal order form, dated 09/11/24, documented resident #26 was admitted hospice on 09/11/24. Resident #26's care plan was reviewed and the care plan did not incorporate hospice services into the plan of care. On 12/31/24 at 10:11 a.m., the corporate nurse stated hospice services should have been included on the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34270 Based on observation, record review, and interview, the facility failed to implement a comprehensive care plan intervention regarding falls for one (#21) of three sampled residents reviewed for accident hazards. A Detail Census Report, dated 12/30/24, documented 24 residents resided at the facility. Findings: A facility policy titles Fall Prevention Program, read in part, High Risk Protocol: a. The resident will be place on the facility's Fall Prevention Program. i. Indicate fall risk on the care plan. ii. Place Fall Prevention indicator (such as star, color coded sticker) on the name plate to the resident's room. A fall risk focus in Resident #21's care plan, dated 10/20/24, read in part, Follow facility fall protocol. A fall risk assessment, dated 11/16/24, documented Resident #21 was scored as a high risk for falls. On 12/31/24 at 1:11 p.m., Resident #21's room door was inspected for an indication they were on the fall protocol. No indicator on the resident's door or walker was observed. On 01/02/25 at 9:38 a.m., LPN #1 stated there was no indicator on the door or in the room of Resident #21 that indicated they were a high risk for falls. They stated they received annual training on the fall protocol, but was unaware of the need for markers on the doors. On 01/02/25 at 9:49 a.m., DON stated the facility had not been able to start the fall protocol yet, but were in the process. They stated they are going to use an apple sticker to indicate high fall risk. They stated they dropped the ball on not starting the program.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42171 Based on record review and interview, the facility failed to ensure a gradual dose reduction was addressed by the physician and residents did not receive psychotropic medications on an as needed basis for more than 14 days for one (#16) of five sampled residents reviewed for unnecessary medications. The DON reported 21 residents received psychotropic medications. Findings: Resident #16 had diagnoses which included generalized anxiety disorder and major depressive disorder. A physician's order, dated 09/11/23, documented the resident was to receive alprazolam (an antianxiety medication) 0.5 mg as needed every 8 hours. The order did not have an end date. A GDR, dated 04/02/24, read in parts, This resident is currently on PRN alprazolam 0.5mg q8h with the following diagnosis: anxiety .Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the resident's medical record and indicate the duration for the PRN order . The GDR was not signed by the physician and no rationale was provided. A review of Resident #16's medical record did not document a rationale from the physician as to why the medication was indicated for more than 14 days. On 01/02/25 at 9:55 a.m., the DON stated as needed psychotropics should only be prescribed for 14 days unless a rationale was provided by the physician. They also stated the GDR dated 04/02/24 had not been addressed by the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42171 Based on observation, record review, and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety. The DON reported 24 residents receive meals from the kitchen. Findings: An undated facility policy titled food Safety Requirements, read in parts, Dry food storage- keep foods/beverages in a clean dry area off the floor .Holding- staff shall monitor food temperature while holding for delivery to ensure proper hot and cold holding temperatures are maintained .All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. An initial tour of the kitchen was conducted on 12/30/24 at 8:13 a.m. The following observations were made: a. the paper towel dispenser at the handwashing sink was out of paper towels, b. the Low Temperature Dish Machine Temperature Form had no documented temperatures or chemical concentrations since 10/21/24, c. there was an open gallon container of milk without documentation of the date it was opened, d. there was an open container of sliced cheese without documentation of the date it was opened, and e. a case of canned pineapple tidbits and red kidney beans were sitting directly on the floor. On 12/30/24 at 8:30 a.m., the DM stated the chemical concentration and temperature of the dish machine were tested daily, but they were not documented. They also stated all opened items should have the date they were opened documented and food items should not be stored on the floor. On 12/30/24 at 12:55 a.m., a case of cucumbers was observed sitting on top of the hand washing sink. A cardboard box was also observed sitting on top of the lid to the trash can. The box contained trash. On 12/30/24 at 1:15 p.m., the DM stated nothing should be placed on top of the trash can lid or the handwashing sink. On 12/31/24 at 10:04 a.m., the DM was asked to provide documentation of the meal holding temperatures. The DM stated they did not have documentation related to the holding temperatures of meals served in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42171 Based on observation and interview, the facility failed to implement an enhanced barrier precaution policy to prevent the spread of MRDO's in the facility. The DON reported the census in the facility was 24. Findings: On 12/30/24 at 8:45 a.m., a tour of the facility was conducted. No signage was noted indicating enhanced barrier precautions were in place to protect at risk residents. On 01/02/25 at 10:26 a.m., CNA #1 stated the facility did not use EBP. On 01/02/25 at 10:28 a.m., CNA #2 stated they were not familiar with EBP. On 01/02/25 at 10:31 a.m., LPN #1 stated to their knowledge the facility was not using EBP. On 01/02/25 at 10:35 a.m., the DON stated they are currently not using EBP. ' ' ' ''''''''''''''''''''''''''''''''''''