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	11/21/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure daily weights were obtained according to physician orders for 1 (#1) of 3 sampled residents reviewed for daily weights.The administrator identified 114 residents resided in the facility. Findings:A 24-hour skin assessment, dated 09/05/25 at 8:11 p.m., showed Resident #1 had bilateral lower extremity pitting edema and weeping of the right leg.A review of the vitals tab in the facility electronic health record showed on 09/06/25 Resident #1 weighed 256.3 pounds and on 09/23/25 Resident #1 weighed 273.2 pounds. Daily weights were not obtained in the month of September after an order was received from the hospital for daily weights on 09/23/25.A review of the vitals tab in the facility electronic health record showed on 10/14/25 Resident #1 weighed 267.5 pounds. Daily weights were not obtained in the month of October.A comprehensive assessment, dated 09/15/25, showed Resident #1 had a brief score for mental illness of 15 which indicated the resident was cognitively intact for daily decision making. The assessment showed diagnoses which included coronary artery disease, hypertension, peripheral vascular disease, respiratory failure, ischemic cardiomyopathy, and a history of coronary artery bypass graft.Hospital discharge orders, dated 09/23/25, showed discharge instructions to weigh Resident #1 daily and to notify the physician if a gain of three pounds or more in 48 hours or less. A physician visit note, dated 09/24/25, showed Resident #1 was seen by the APRN for a chronic care follow-up after hospital readmission. The note showed the current weight of 273 pounds and a previous weight of 256 pounds on 09/06/25. The note showed this was a gain of 17 pounds. There were no new orders.A review of October 2025 active orders for Resident #1 showed no orders to weigh daily or to restrict fluid intake.A progress note, dated 10/09/25 at 10:35 a.m., showed the left arm of Resident #1 was red and swollen with clear liquid drainage. The note showed an order was received for an antibiotic for seven days.A care plan, revised 10/14/25, showed cellulitis to the left upper extremity with risks for complications. The care plan showed a problem for peripheral vascular disease with interventions to include elevating the edematous extremity to promote venous return. The care plan did not show an intervention to weigh Resident #1 or to restrict their fluid intake. A progress note, dated 10/15/25, showed Resident #1 called 911 themself to go to the hospital due to cellulitis in their arm. A hospital clinical update, dated 10/15/25, read in part, CHIEF COMPLAINT: HISTORY OF PRESENT ILLNESS: 60 y.o. [year old] [sex omitted] presents to [hospital name withheld] for further evaluation of fluid overload. Per patient report [Resident #1] has been having increasing swelling in [their] lower extremities as well as [their] left upper extremity over the last 7 to 10 days. Patient also has admitted shortness of breath and orthopnea [shortness of breath while lying down]. Patient also admits to decreased appetite .Due to [their] increased swelling at the nursing home family called 911 from nursing home for patient to be taken from nursing home to ER [emergency room] for further evaluation and treatment. In the emergency department patient with chest x-ray concerning for pulmonary congestion [a condition where fluid accumulates in the lungs] and worse left sided atelectasis [a partial or complete collapse of the lung tissue] . Due to elevated troponin [lab test which indicates damage to the heart muscle or indicates heart failure] and BNP [brain natriuretic peptide is a hormone the heart releases when it is under stress, like heart failure] concern patient congestive heart failure exacerbation.A hospital Clinical Update, dated 10/22/25, showed Resident #1 was admitted to the hospital on [DATE] with a principal problem of congestive heart failure exacerbation and a weight of 291.45 pounds. The clinical update showed the last hospital weight on 09/23/25 was 273.81 pounds. This was a gain of 6% in one month.On 10/24/25 at 9:41 a.m., licensed practical nurse #1 stated the protocol for monitoring fluid overload was to weigh daily at the same time. They stated they would expect to obtain daily weights on residents with CHF or if bilateral edema was noted.On 10/24/25 at 9:47 a.m., the DON stated the nurse management entered the hospital discharge orders. They stated the best practice for monitoring fluid overload was intake and output monitoring and weights. The DON stated they would typically obtain weights for residents who had a diagnosis of CHF, but not always, if it were well controlled.On 10/24/25 at 10:41 a.m., the DON stated they did not show a diagnosis of CHF for Resident #1 and did not have a justified reason to obtain daily weights or intake and output volumes.On 10/24/25 at 10:23 a.m., the APRN stated the best practice for monitoring fluid overload for a resident with CHF would depend on how controlled they were, but if they were not controlled then they would order daily weights then weekly weights, and trend shortness of breath or edema. They stated they had noted Resident #1 had gained weight, but did not feel it was fluid overload. The APRN stated Resident #1 was hypotensive