

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Maplewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41318</p> <p>Based on record review and interview, the facility failed to ensure an assessment was transmitted timely for one (#87) of two sampled assessments reviewed for accuracy.</p> <p>The Administrator identified 109 residents resided in the facility.</p> <p>Findings:</p> <p>A Face Sheet, documented Resident #87 expired [DATE].</p> <p>A Death In Facility assessment, dated [DATE], documented In Progress.</p> <p>On [DATE] at 1:23 p.m., MDS Coordinator #2 stated they double check assessments at the end of each month to ensure resident assessments were completed. They stated they were unsure the time frame for ensuring a Death In Facility assessment was completed but they were usually completed within 48 hours.</p> <p>On [DATE] at 1:23 p.m., MDS Coordinator #2 reviewed Resident #87's assessment and stated it showed it was still in progress. They reviewed the assessment and stated there was a warning they needed to clear before it was finalized. They stated they didn't know why it wasn't caught with there double check procedure. They stated the assessment was completed but had not been submitted timely.</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure medications were administered as ordered for one resident (#58) of six sampled resident reviewed for medications.</p> <p>The Administrator stated 109 residents resided in the facility.</p> <p>Findings:</p> <p>A Medication Ordering and Receiving from Pharmacy, policy read in part, .Reorder medications four days in advance of need .to ensure adequate supply is on hand .</p> <p>Resident #58 had diagnoses which included epilepsy, unspecified, not intractable, without status epilepticus.</p> <p>A care plan problem for seizures, dated 03/01/24, documented Resident #58's was to be administered medications as ordered.</p> <p>A controlled drug disposition report, dated 02/09/24, documented 60 doses of phenobarbital 64.8 mg had been delivered to the facility for the use of Resident #58. The report documented the last dose of the original 60 doses was signed out on 03/18/24 at 6:00 p.m.</p> <p>A medication administration record, dated 03/01/204 through 03/20/24, documented a dose of phenobarbital 64.8 mg was scheduled to be administered to Resident #58 on 03/19/24 between 5:30 a.m. and 6:30 a.m. The record documented the medication was not available to be administered to the resident.</p> <p>A medication administration record, dated 03/01/204 through 03/20/24, documented Resident #58 did not receive the AM or PM doses of phenytoin sodium 200 mg on 03/18/24. It documented the medication was not available.</p> <p>A controlled drug disposition report, dated 03/19/24, documented six doses of phenobarbital 64.8 mg had been delivered to the facility for the use of Resident #58. The report documented the first dose of the original six was signed out on 03/19/24 at 7:59 p.m.</p> <p>A progress note, dated 03/19/24 at 10:36 p.m., documented Resident #58 stated they had two seizures. It documented the resident was sent to the hospital per the resident's request.</p> <p>A progress note, dated 03/20/24 at 2:28 a.m., documented Resident #58 returned to the facility with a diagnosis of seizure like activity and a new order for phenytoin sodium 200 mg twice a day. It documented this was the current dose for the medication.</p> <p>On 03/20/24 at 1:34 p.m., CMA #1 stated Resident #58 had run out of phenobarbital 64.8 mg on 03/18/24 and it was ordered. They stated six doses of the medication arrived on 03/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 2:03 p.m., the ADON was shown Resident #58's March medication administration record and was asked if the medications had been administered as ordered. They stated, No.</p>