

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Oklahoma Memory Care Institute		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 East 28th Street Tulsa, OK 74114	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41809</p> <p>Based on record review and interview, the facility failed to report injuries of unknown origin to required agencies for one (#1) of three sampled residents who were reviewed for injuries of unknown origin.</p> <p>The DON identified 47 residents resided at the facility.</p> <p>Findings:</p> <p>Resident #1 had diagnoses which included vascular dementia, anxiety, and frequent falls.</p> <p>A review of incident reports for Resident #1 revealed two incident reports for injuries of unknown origin on 10/26/24 and 12/10/24. Both were bruising, first to the temple and then to the right upper thigh.</p> <p>Review of state reports revealed the injury of unknown origin, dated 01/16/25, for a right subcapital femoral neck fracture (a fracture that occurs in the neck of the femur, specifically at the junction where the femoral head meets the neck), was reported to OSDH on 01/17/25. No state reports were located for the 10/26/24 and 12/10/24 injuries of unknown origin.</p> <p>On 01/29/25 at 3:00 p.m., CNA #1 stated they reported falls, wounds, skin tears, pain, soreness, and red and purple bruises to the nurse.</p> <p>On 01/29/25 at 3:05 p.m., LPN #1 stated when they received reports of injuries of unknown origin, they checked the resident, provided care, and notified the DON, physician, and resident representative(s).</p> <p>On 01/29/25 at 3:20 p.m. the DON stated they reported to the state, falls with injuries, abuse allegations, and injuries of unknown origin. The DON stated they investigated and tried to determine how the injury occurred.</p> <p>On 01/29/25 at 3:27 p.m., the DON stated they had completed the risk management, but were unable to locate the state reports for 10/26/24 and 12/10/24. They stated they did not know why the state reports were not completed.</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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