STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375468	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oklahoma Memory Care Institute	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41220 A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 01/30/25 related to the facility's failure to supervise and prevent a resident from elopement. The facility failed to prevent Resident #1 from eloping from the facility which had the potential to result in serious injury or harm. On 02/11/24, the Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to protect and prevent accident hazards related to elopement. The past noncompliance IJ was removed effective 01/31/25 after the facility put measures in place to prevent recurrence. On 01/31/25 compliance rounds were initiated, the quality assurance committee met, an inservice on elopement risk and documentation of hourly rounds were completed by all direct care staff, outside window locks were replaced by locks that allowed limited opening, Based on observation, record review, and interview, the facility failed to provide supervision to prevent elopement for 1 (#1) of 3 sampled residents reviewed for supervision. The administrator identified 47 residents in the facility. Findings: Resident #1 had diagnoses which included dementia. A Medicare admission assessment, dated 01/15/25, showed the resident was severely impaired for daily decision making. A progress note, dated 01/29/25 at 8:31 p.m., showed the resident had barricaded their door with a chair. A progress note, dated 01/30/25 at 7:30 a.m., showed the facility received a phone call from a local hospital inquiring if Resident #1 was a resident at the facility. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A final incident report, dated 01/31/25, showed after an investigation the facility determined the resident was last seen in the facility on 01/29/25 at 10:30 p.m. The window in the resident's room was found to be opened and the screen removed. The report showed Resident #1 was picked up by an ambulance service at a convenience store on 01/30/25 at 1:29 a.m. and transported to a local hospital. The hospital found Resident #1 to be uninjured and the resident was returned to the facility at 8:55 a.m. where the resident was placed on continuous supervision. Resident #1 was sent to a local hospital for a psychological evaluation at 12:21 p.m. at the request of resident's guardian. Resident #1 returned to the facility at 7:30 p.m. that day and was kept on continuous supervision with a sitter in their room. Resident #1 was discharged from the facility on 1/31/25 at 1:32 p.m. for further psychological evaluation. On 02/03/25 at 10:42 a.m., the administrator stated the two staff members who failed to round on the resident were terminated and all other staff were immediately educated regarding making hourly rounds. The administrator stated a new system for hourly documented rounds was initiated that day and new locks were ordered for all outside windows. The administrator stated the new locks allow for a limited opening of all outside windows. The administrator stated the locks were installed on 01/31/25. The administrator stated the locks were monitored weekly by the maintenance staff and they also monitored with their own check of the windows. The administrator stated the director of nursing monitored the hourly rounds by staff, and all were reviewed at the facility quality assurance meeting. Documentation of the monitoring, education of staff, and review by the quality assurance committee was provided.