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	03/18/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to maintain an abuse free environment for 3 (#2, 3, and #4) of 5 sampled residents reviewed for abuse. The administrator identified 38 residents resided in the facility. Findings:A facility policy titled Abuse, Neglect and Exploitation, implemented 01/2026, read in part, The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse.1. A quarterly assessment for Resident #2, dated 01/09/26, showed the resident had a BIMS score of 3, which indicated the resident was severely impaired in cognition, and utilized a manual wheelchair for mobility.A nurse's progress note for Resident #2, dated 02/20/26, showed CNA #1 reported Resident #2 was on the floor in a resident's room. The progress note showed CNA #1 observed Resident #1's walker outside of the room and when CNA #1 attempted to enter the room, they met some resistance from a wheelchair pushed against the inside of the door. The progress note showed CNA #1 observed Resident #1 attempting to remove the shirt off Resident #2. CNA #1 pulled the shirt back in place, separated the residents, and called for assistance. The progress note showed LPN #1 entered the room and escorted Resident #1 back to the common area. LPN #1 described Resident #1's mentation as at baseline, confused, with the resident not knowing where they were and what they had done. The progress note showed Resident #2 was initially anxious but calmed quickly and returned to their baseline. On 03/11/26 at 5:25 p.m., CNA #1 stated they observed Resident #1's walker outside of a resident's room. CNA #1 stated they entered the room and observed Resident #1 sitting on the bed with Resident #2 sitting on the floor and Resident #1 holding onto the waistband of Resident #2's pants, at the hip, and pulling downward, exposing the edge of Resident #2's underwear. CNA #1 stated Resident #2's hip was barely exposed and when they asked Resident #1 to stop, they did. CNA #1 stated there was a wheelchair, an oxygen concentrator, and a walker which was purposefully spread in a crescent shape around Resident #2. CNA #1 stated they kept the two residents separated and called for assistance. CNA #1 stated LPN #1 escorted Resident #1 from the room without incident. CNA #1 stated a short time later, neither resident was upset. CNA #1 stated the facility staff closely monitored Resident #1. CNA #1 stated they received training on abuse, neglect, and working with residents diagnosed with dementia. On 03/16/26 at 12:45 p.m., the DON stated they were notified CNA #1 found Resident #1 and Resident #2 barricaded in a resident's room with Resident #1 attempting to remove clothing from Resident #2. The DON stated they placed Resident #1 on close supervision and started screening residents, asking if they saw or experienced abuse at the facility, and if they felt safe in the facility. 2. A comprehensive assessment for Resident #3, dated 02/12/26, showed the resident had a BIMS score of 00, which indicated they were severely impaired in cognition, and was completely dependent with activities of daily living. A nurse's progress note for Resident #3, dated 03/03/26, showed LPN #1 was notified by CMA #1 that while they were in Resident #3's room administering medications to their roommate, they overheard CNA #2 and CNA #3 working with Resident #3. The progress note showed CMA #1 claimed to have overheard the two (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

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 03/18/2026
NAME OF PROVIDER OR SUPPLIER Oklahoma Memory Care Institute		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 East 28th Street Tulsa, OK 74114	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNAs refer to Resident #3 in a derogatory manner. The progress note showed LPN #1 and LPN #2 assessed Resident #3 and determined the resident was frightened and had several small, round shaped, bruises measuring approximately one to two centimeters and had two crescent shaped skin tears to their right forearm.On 03/11/26 at 4:35 p.m., LPN #1 stated they, along with LPN #2, assessed Resident #3. LPN #1 stated they found the resident to be very tense with their arms drawn in toward themselves. LPN #1 stated Resident #3 had bruising about the size of fingertips and two crescent shaped skin tears similar in shape and size to the curve of a fingernail. On 03/11/26 at 5:00 p.m., CMA #1 stated they were in the room of Resident #2, next door to Resident #3, when they overheard CNA #4 refer to Resident #3 in a derogatory manner. CMA #1 stated they returned to their medication cart, gathered the medications for Resident #3's roommate, and entered Resident #3's room. CMA #1 stated the two CNAs were no longer in the room and CMA #1 checked on both residents. CMA #1 stated Resident #3 usually laughed when they entered the room but instead, Resident #3 was tense with their back straight and arms drawn tightly into the body. CMA #1 stated they asked Resident #3 if the CNAs who were just in the room hurt them and Resident #3 responded yes. CMA #1 stated Resident #3 was rarely verbal but would sometimes answer with one- or two-word responses. CMA #1 stated they reported what they overheard and observed to their charge nurse. 3. The quarterly assessment for Resident #4, dated 02/19/26, showed the resident had a BIMS score of 3, which indicated the resident was severely impaired in cognition, and was dependent in activities of daily living. A state reportable incident report, dated 03/03/26, read in part, [CNA #3] stated [they] witnessed [CNA #2] 'pop' [Resident #4] on [their] arm/hand after resident hit [CNA #2] after changing. The incident report showed CNA #2 stated they only tapped Resident #4 on the wrist four times because Resident #4 allegedly grabbed CNA #2 by their waist and chest.On 03/16/26 at 12:44 p.m., the DON stated when the allegation of abuse toward Resident #4 was made, the nurse assessed Resident #4 and no injuries were noted.On 03/16/26 at 12:45 p.m., the DON stated on 03/03/26, the charge nurse contacted them and reported an allegation of abuse against CNA #2 and CNA #3. The DON stated they immediately returned to the facility and started their investigation. The DON stated during the investigation, they interviewed CNA #2 and CNA #3 separately. The DON stated neither CNA knew who came forward with the allegation of abuse toward Resident #3. The DON stated when they interviewed CNA #3, the CNA accused CNA #2 of abusing Resident #4. The DON stated both CNAs turned on each other and accused the other of abuse towards residents, but neither could answer why they had not reported the abuse to their charge nurse. The DON stated the two CNAs were terminated because of the allegations of abuse and not following the facility's abuse policy.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to perform a background check for 1 (PCW #1) of 1 personal care worker contracted by a family to care for an individual resident. The DON identified one resident whose family contracted a private sitter.Findings:A facility policy titled Abuse, Neglect and Exploitation, implemented 01/2026, read in part, Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.On 03/18/26 at 10:20 a.m., PCW #1 stated they were a home health aide contracted with the family of Resident #5 to provide care and company to Resident #5. PCW #1 stated they worked with Resident #5 for several years and continued to work with them when they moved to the facility in September of 2025. On 03/18/26 at 11:00 a.m., the DON stated they were not aware the facility needed to perform a background check on someone contracted by the family to provide care to a particular resident and doubted the facility had performed a background check on PCW #1. On 03/18/26 at 11:30 a.m., corporate nurse #1 stated the facility had not performed a background check on PCW #1. The corporate nurse reviewed the facility policy and stated they did not follow the screening portion of their policy.