

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  10/31/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity by being called their preferred name for three (#18, 20, and #24) and failed to ensure dignity with dining for nine (#5, 10, 12, 15, 18, 26, 33, 34, and #44) of eight sampled residents who were reviewed for dignity.</p> <p>The DON identified eight residents who were dependent on staff for meals who ate in the dining room.</p> <p>Findings:</p> <p>An undated Promoting/Maintaining Resident Dignity During Mealtimes policy, read in part, .All staff will be seated, if possible, while feeding a resident .</p> <p>1. On 10/28/24 at 8:21 a.m., the DON was observed to assist dependent residents with the morning meal in the dining room. The DON was observed to stand while assisting Resident #44, 33, and Resident #5.</p> <p>On 10/28/24 at 12:12 p.m., the DON was observed to assist dependent residents with the noon meal in the dining room. The DON was observed to stand while assisting Resident #18, 15, 26 and Resident #10.</p> <p>On 10/28/24 at 12:18 p.m., the ADON was observed to assist dependent residents with the noon meal in the dining room. The ADON was observed to stand while assisting Resident #12, 5, 33, and Resident #34.</p> <p>On 10/30/24 at 1:51 p.m., the DON stated the wheel chairs and geri chairs were too large for them to sit while assisting the residents with meals. The DON stated they should sit while assisting residents with meals to ensure dignity was maintained.</p> <p>2. Resident #18 had diagnoses which included Alzheimer's disease.</p> <p>The Care Plan, dated 10/10/24, read in part, .Personal Preference Care Plan .I prefer to be address [sic] by being called [Resident's first name withheld] .</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/29/24 at 1:36 p.m., CNA #1 stated to Resident #18, Take a bite grandma, in the common area of the facility.</p> <p>On 10/29/24 at 1:58 p.m., CNA #2 stated to Resident #18, Hold on momma, alright momma?</p> <p>3. Resident #24 had diagnoses which included Alzheimer's disease.</p> <p>The Care Plan, dated 01/08/24, read in part, .Personal Preference Care Plan .I prefer to be address [sic] by being called [Resident's first name withheld] .</p> <p>On 10/29/24 at 1:55 p.m., CNA #2 stated to Resident #24, What you doing momma?</p> <p>4. Resident #20 had diagnoses which included dementia.</p> <p>The Care Plan, dated 10/10/24, read in part, .Personal Preference Care Plan .My name is [Resident's first name withheld] .</p> <p>On 10/28/24 at 8:47 a.m., CNA #2 was observed to call Resident #20 momma while assisted them with the morning meal.</p> <p>On 10/29/24 at 11:42 a.m., LPN #1 stated to Resident #20, [NAME] I'm gonna put [their] on our face ok? [NAME], [NAME], we are gonna do your breathing treatment, okay?</p> <p>On 10/30/24 at 1:06 p.m., CNA#2 stated they addressed residents as sir or ma'am. CNA #2 stated it was a bad habit to call residents names other than their preferred name. They stated no residents had asked them to call them momma.</p> <p>On 10/30/24 at 1:09 p.m., CNA #1 stated they called Resident #18 'grandma' as a term of endearment, but should address the resident by their preferred name.</p> <p>On 10/30/24 at 1:18 p.m., LPN #1 stated '[NAME]' was not the preferred name for Resident #20. They stated staff should address residents by their preferred name.</p> <p>On 10/30/24 at 2:04 p.m., the DON stated staff were to address residents by their preferred name.</p> <p>41809</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure assessments were accurate for one (#9) of one sampled residents reviewed for accuracy of assessments.</p> <p>The administrator identified 48 residents who resided in the facility.</p> <p>Findings:</p> <p>Resident #9 had diagnoses which included dementia.</p> <p>The admission assessment, dated 08/11/24, documented the resident was on an anticoagulant medication and was not on an antiplatelet medication.</p> <p>Review of the physician orders revealed the resident was on Plavix (an antiplatelet medication), but there was no documentation an anticoagulant medication had been ordered.</p> <p>On 10/30/24 at 11:31 a.m., the MDS coordinator stated the resident was on Plavix and they had coded the medication as an anticoagulant instead of an antiplatelet medication.</p> <p>On 10/30/24 at 12:59 p.m., the DON stated the corporate office reviewed the assessments for accuracy.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41809</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were transferred safely with a mechanical lift for two (#21 and #18) of two sampled residents reviewed for mechanical transfers.</p> <p>The DON identified four residents who utilized a mechanical lift.</p> <p>Findings:</p> <p>1. Resident #21 had diagnoses which included dementia, anxiety, and heart failure.</p> <p>A care plan for Resident #21, initiated 02/28/24, documented to transfer with two staff using the mechanical lift.</p> <p>On 10/28/24 8:04 a.m., CNA #2 entered the room of Resident #21 alone with the mechanical lift.</p> <p>On 10/28/24 at 8:29 a.m., CNA #2 opened the door to the room of Resident #21. The mechanical lift was observed in the room and the resident was observed to be in their wheel chair with the sling under them.</p> <p>On 10/30/24 at 1:37 p.m., CNA #2 stated Resident #21 was transferred using the mechanical lift. CNA #2 stated they did not transfer Resident #21 using two staff because the resident told them to go ahead and get him up without two staff.</p> <p>2. Resident #18 had diagnoses which included Alzheimer's and dementia.</p> <p>A care plan focus for daily care, initiated 12/29/23, documented Resident #18 required two staff with the mechanical lift to transfer them.</p> <p>On 10/29/24 at 1:45 p.m., Resident #18 was observed to be taken to their room by CNA #2 after returning from the doctor with the lift sling under the them.</p> <p>On 10/29/24 at 1:47 p.m., CNA #2 left the room.</p> <p>On 10/29/24 at 1:52 p.m., CNA #2 was observed to enter the room of Resident #18 with the mechanical lift.</p> <p>On 10/29/24 at 1:58 p.m., the surveyor entered the room of Resident #18 and observed one staff. CNA #2 was observed to lower Resident #18 onto the bed. CNA #2 instructed Resident #18, Hold on momma, alright momma.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/30/24 at 2:00 p.m., the DON stated two staff were required for all mechanical lift transfers. They stated the staff had been in-serviced multiple times with no effect. The DON was asked the reason staff were not using two staff with mechanical lift despite in-services. They stated, I just keep in-servicing over and over again.</p> <p>35474</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35474</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were monitored during nebulizer treatments for one (#20) of one sampled residents reviewed for respiratory care.</p> <p>The DON identified one resident who had orders for nebulizer treatments.</p> <p>An undated Nebulizer Therapy policy, read in part, .Observe resident during the procedure for any change in condition .</p> <p>Resident #20 had diagnoses which included chronic obstructive pulmonary disease.</p> <p>A physician order, dated 10/06/24, documented the resident was ordered ipratropium-albuterol (broncodilator) 0.5-2.5 (3mg/3ml) inhale every six hours.</p> <p>On 10/28/24 at 8:47 a.m., CNA #2 was observed to turn off the nebulizer machine and remove the nebulizer mask from Resident #20.</p> <p>On 10/29/24 at 11:42 a.m., LPN #1 was observed to prepare and administer ipratropium-albuterol via nebulizer to Resident #20. LPN #1 stated, Sometimes [they] keep it on, sometimes [they] won't when they placed the nebulizer mask on the resident.</p> <p>On 10/29/24 at 11:48 a.m., LPN #1 left the resident's room with the nebulizer mask in place. LPN #1 stated they normally left the nebulizer in place six or seven minutes then returned and removed it.</p> <p>On 10/29/24 at 12:05 p.m., Resident #20 was observed to hold the nebulizer mask in their right hand away from their face.</p> <p>On 10/29/24 at 12:12 p.m., LPN #1 returned to the resident's room and turned off the nebulizer machine. Resident #20 was observed to still hold the nebulizer mask in their right hand away from their face.</p> <p>On 10/30/24 at 1:27 p.m., LPN #1 stated they did not know how much of the medication the resident had received during the breathing treatment. They stated they had been informed on 10/29/24, after the breathing treatment for Resident #20, they were to stay in the room with the resident during breathing treatments to ensure the full treatment was received.</p> <p>On 10/30/24 at 1:59 p.m., the DON stated nurses were to stay with the residents for the entirety of nebulizer treatments.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>41809</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was accurately assessed for the safe use of bed rails for one (#98) of three sampled residents reviewed for bed rails.</p> <p>The DON identified four residents who had bed rails applied to their beds.</p> <p>Findings:</p> <p>An undated facility Proper Use of Bed Rails policy, read in part, Appropriate alternative approaches are attempted prior to installing or using bed rails .If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails .</p> <p>Resident #98 had diagnoses which included, Alzheimer's disease, dementia, and repeated falls.</p> <p>A review of falls for Resident #98 revealed a witnessed fall on 10/09/24, a witnessed fall on 10/16/24, an un-witnessed fall on 10/17/24, and an un-witnessed fall on 10/30/24 in their room during the hours of sleep.</p> <p>A Fall Risk Assessment, dated 10/23/24, documented Resident #98 was a high fall risk.</p> <p>A care plan, initiated 10/28/24, documented bed rails (two half rails), were added to Resident #98's bed for sacral wound, comfort, and mobility.</p> <p>A Bed Rail/Assist Bar Evaluation, dated 10/28/24, documented Resident #98 had no cognitive deficit and had no balance issues.</p> <p>On 10/31/24 at 11:57 a.m., CNA #3 stated Resident #98 transferred with one person assist and was independent for bed mobility. They stated Resident #98 had not fallen out of bed to their knowledge.</p> <p>On 10/31/24 at 12:02 p.m., LPN #2 stated Resident #98 transferred with one person assist and required some assistance with bed mobility. LPN #2 stated Resident #98 had fallen the night before and was on neuro checks. They stated bed rails were checked to ensure they were secure by staff and maintenance conducted a bed rail check.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/31/24 at 12:06 p.m., the ADON stated they thought Resident #98 was bed bound from the initial records received, but when Resident #98 was admitted they had tolerated the wheel chair well and was getting stronger. They stated the ADON, DON, and MDS nurses were responsible to complete bed rail/assist bar evaluations. The ADON stated they had completed the assessment for Resident #98. They stated they had been involved with the care for Resident #98 and so they knew what the resident could and could not do. The ADON was asked how they determined Resident #98 had no cognitive deficit. They stated they just took it as fluctuations of consciousness and Resident #98 was pretty baseline with everything. The ADON was asked how they determined Resident #98 had no balance issues. They stated, Just by [their] balance sitting up in the chair. The ADON stated Resident #98 had not had any falls out of bed since the bed rails were installed. They reviewed the clinical record and stated, Oh, [they] had one last night.</p> <p>On 10/31/24 at 12:16 p.m., the DON stated they and the ADON were responsible to ensure evaluations/assessments were completed accurately. They stated bed rails were utilized for Resident #98 to assist them with bed mobility. The DON stated Resident #98 could get up because the rails were quarter rails and the rails were mainly to assist the resident and keep them safe. The DON clarified the previous statement to keep Resident #98 from injury. The DON stated the IDT made the final determination for bed rails based on risk and benefits and if the bed rails were safe and not a potential accident hazard. The DON reviewed the bed rail/assist bar evaluation for Resident #98 and stated the assessment was not accurate. They stated they had not reviewed the bed rail/assist bar evaluation after it was completed by the ADON on Monday. The DON stated the bed for Resident #98 was changed to a bed with rails on Monday 10/28/24.</p> <p>On 10/31/24 at 12:28 p.m., the director of maintenance stated they installed the bed rails but, they did not perform continued safety checks. They stated they just checked them if they were informed the bed rails were loose, and then they tightened the bed rails.</p> <p>On 10/31/24 at 12:37 p.m., the bed rail on the resident's bed was observed. There was a gap of more than a hand's width between the mattress and the bed rail.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35474</p> <p>Based on observation, interview, and record review, the facility failed to ensure insulin was dated when opened for one (treatment cart #1) of two medication carts observed for medication storage.</p> <p>The DON identified four medication carts in the facility and five residents who were ordered insulin.</p> <p>Findings:</p> <p>An undated Labeling of Medications and Biologicals policy, read in part, .Labels for multi-use vials must include .The date the vial was initially opened or accessed .</p> <p>An undated Insulin Pen policy, read in part, .Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation .</p> <p>On 10/30/24 at 9:58 a.m., treatment cart #1 was observed with LPN #1. The following medications were observed to be opened and not dated.</p> <ul style="list-style-type: none"> <li>a. Lantus insulin vial for Resident #15;</li> <li>b. Fiasp flex touch pen for Resident #10;</li> <li>c. insulin aspart pen for Resident #27;</li> <li>d. insulin aspart pen and Basaglar pen for Resident #42;</li> <li>e. Levemir pen and insulin aspart for Resident #1; and</li> <li>f. glucose check strips.</li> </ul> <p>On 10/30/24 at 10:02 a.m., LPN #1 stated they did not know what date the above listed insulin vial, insulin pens, or glucose check strips had been opened.</p> <p>On 10/30/24 at 10:08 a.m., the DON reviewed the above listed insulin vial, insulin pens, and glucose check strips and stated staff were to date insulin and glucose check strips when they were opened. They stated medication/treatment carts were monitored monthly by the pharmacy consultant.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35474</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview, the facility failed to ensure infection control was maintained during dining for two (morning and noon meal) of two meals observed.</p> <p>The DON identified eight residents who were dependent on staff for meals.</p> <p>On 10/28/24 at 8:27 a.m., the DON was observed to assist four residents with the morning meal. The DON was observed to pick up a biscuit with jelly with their bare hands and place it to a resident's mouth without sanitizing their hands.</p> <p>On 10/28/24 at 12:12 p.m., the ADON was observed to assist four residents with the noon meal. The ADON was observed to assist a resident with a drink by touching the straw then continue to assist other residents with their meal without sanitizing their hands.</p> <p>On 10/28/24 at 12:18 p.m., the DON was observed to pick up a dinner roll and hand it to a resident they were assisting without sanitizing their hands.</p> <p>On 10/30/24 at 1:51 p.m., the DON stated staff should not directly touch residents' food or straws with their bare hands.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure documentation was maintained that staff were educated and offered the COVID-19 vaccine for two of two employees reviewed for the COVID-19 vaccination.</p> <p>The COVID-19 Vaccination policy, dated 06/27/23, read in part, .The facility will maintain documentation related to staff COVID-19 vaccination and includes at a minimum: a. Education to the staff regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; c. The COVID-19 vaccine status of staff .</p> <p>On 10/31/24 at 3:03 p.m., the infection preventionist stated they did not have any documentation related to staff education of the COVID-19 vaccination for CNA #2.</p> <p>On 10/31/24 at 3:55 p.m., the administrator stated they did not have documentation for CNA #4 regarding staff education of the COVID-19 vaccination.</p> <p>On 10/31/24 at 4:08 p.m., the administrator stated they discussed the COVID-19 vaccination with new employees during orientation, but they did not maintain documentation of the education/information provided for any of the staff.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>41809</p> <p>Based on observation, interview, and record review, the facility failed to ensure ongoing monitoring and supervision of bed rails for one (#98) of one resident sampled for bed rails.</p> <p>The DON identified four residents who had bed rails.</p> <p>Findings:</p> <p>An undated facility Proper Use of Bed Rails policy, read in part, Appropriate alternative approaches are attempted prior to installing or using bed rails .If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails .</p> <p>Resident #98 had diagnoses which included, Alzheimer's disease, dementia, and repeated falls.</p> <p>On 10/31/24 at 12:16 p.m., the DON was asked what kind of assessment was done after the bed rails were applied. They stated a bed rail assessment was completed by the ADON.</p> <p>On 10/31/24 at 12:28 p.m., the director of maintenance stated they installed the bed rails, but they did not perform continued safety checks. They stated they just checked them if they were informed the bed rails were loose, and then tightened the bed rails.</p> <p>On 10/31/24 at 12:37 p.m., the bed rail on the resident's bed was observed. There was a gap of more than a hand's width between the mattress and the bed rail.</p>