

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Memory Care Center at Emerald		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 North Hickory Street Claremore, OK 74017	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to protect the resident's right to be free from neglect for one (# 1) of four residents reviewed for neglect.</p> <p>The Administrator reported the facility census was 53.</p> <p>Findings:</p> <p>A facility policy titled Abuse, Neglect and Exploitation, revised 01/24, read in part, .Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Neglect, as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .</p> <p>Resident #1 had diagnoses which included severe unspecified dementia with anxiety and senile degeneration of the brain.</p> <p>An admission assessment, dated 03/15/24, documented Resident #1 was severely impaired for daily decision making and was able to walk without assistance.</p> <p>A nurse note, dated 05/18/24 at 7:44 pm, documented the CMA on duty notified the nurse that Resident #1 was found laying on the concrete patio in the courtyard, the resident was unresponsive to a sternal rub. The note further documented the staff placed cool wet cloths on the resident and called 911. EMS arrived at approximately 6:50 pm and transported Resident #1 to the hospital.</p> <p>Hospital discharge paperwork, dated 05/24/24, documented Resident #1's diagnoses for hospital admission included heat exhaustion and volume depletion.</p> <p>On 05/31/23 at 9:30 a.m., CNA #1 stated that the courtyard doors should always be locked, and residents shouldn't not be outside without staff.</p> <p>On 05/31/23 at 9:40 a.m., LPN #1 stated staff should always supervise residents when they are outside.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/31/23 at 10:00 a.m., RN #1 stated activities staff usually took the residents outside, they also stated residents should always be supervised and dressed appropriately when outside.</p> <p>On 05/31/23 at 10:15 a.m., CNA #2 stated the courtyard doors should not be propped open and staff members should be supervising residents when they are outside.</p> <p>On 05/31/23 at 10:20 a.m., CNA #3 stated the doors should be secure and residents should not be unsupervised when they are in the courtyard.</p> <p>On 05/31/23 at 10:53 a.m., the ADON stated that they had educated staff regarding propping the courtyard doors open, supervising residents when they are outside, and ensuring residents are dressed properly for the environment. They stated that after Resident #1 was found unresponsive in the courtyard EMS was contacted immediately and the resident was sent to the hospital for treatment related to heat exhaustion.</p> <p>On 05/31/23 at 12:40 p.m., LPN #2 stated they were called to the 600-hall courtyard around 6:40 pm on 05/18/24, they further stated when they arrived, they observed Resident #1 laying on the concrete in the direct sun wearing only a pair of pants. LPN #2 stated Resident #1 was unresponsive to sternal rubs and that EMS was notified immediately. LPN #2 stated the door between the courtyard and the 600-hall was propped open with a chair.</p> <p>On 05/31/24 at 12:48 p.m., CNA #4 stated they were called to the 600-hall around 6:30 pm On 05/18/24, and that when they arrived, they observed Resident #1 laying outside on the concrete patio. They also stated that the door between the courtyard and 600-hall was propped open. CNA #4 stated the resident was red, soaked with sweat, hot to the touch, and unresponsive.</p> <p>On 05/31/23 at 3:00 p.m., the ADON stated they were unsure how long the resident had been in the courtyard, they stated that a CNA reported they offered the resident a snack approximately two hours before he was found unresponsive in the courtyard. The ADON reported Resident #1 was not being adequately supervised.</p> <p>On 05/31/23 at 3:05 p.m., the Administrator stated that Resident #1 was not being supervised appropriately at the time of the incident.</p>