STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375553	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memory Care Center at Emerald	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 (#64) for 3 sampled residents reviewed for abuse.The administrator identified 58 residents resided in the facility.Findings:A facility policy titled Abuse, Neglect and Exploitation, dated 01/2024, read in part, Resident must not be subject to abuse by anyone, including, but no limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardian, friends, or other individuals. Prevention of abuse, Neglect, and Exploitation - The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation. Observe resident behavior and their reactions to other residents, roommates, tablemates.An admission assessment, dated 04/02/26, showed Res #24 had a BIMS score of 6 (a BIMS score of 6 indicated the resident's cognition was severely impaired) and diagnoses that included stroke and dementia. The assessment showed the resident had demonstrated verbal behaviors directed at others in the one to three days of the seven-day look back period. The assessment showed Res #24 did not show any physical behaviors directed at others during the seven-day look back period.An admission assessment, dated 04/28/26, showed Res #64 had a BIMS score of 00 (a BIMS score of 00 indicated the resident's cognition was severely impaired) and had a diagnosis of dementia. The assessment showed the resident did not show any physical or verbal behaviors toward others in the seven-day look back period.A handwritten statement authored by CNA #1, dated 05/16/26, showed CNA #1 had been assisting in a resident room and heard Res #64 make some type of noise. The statement showed CNA #1 entered the common area and observed Res #24 grab Res #64 by the arms and throw Res #64 to the ground.An Alert note, dated 05/16/26 at 3:31 p.m., showed, Res #64 had been shoved to the floor, had been wincing from pain, and had been sent to an acute care hospital.An Incident note, dated 05/16/26 at 4:05 p.m., showed Res #24 was observed aggressively shoving another resident to the floor.An incident report, with an incident date of 05/16/26, showed Res #24 had shoved Res #64 to the ground. The incident report showed Res #64 had been sent to an acute care hospital and found to have had a fracture to their right hip.A hospital discharge record, dated 05/19/26, showed Res #64 had been admitted to the hospital on [DATE] and was diagnosed with a closed displaced fracture of the right femoral neck. The record showed the resident had a surgical procedure to repair the fracture while at the hospital.On 06/02/26 at 3:18 p.m., the administrator stated when the incident occurred with Res #24 and Res #64 on 05/16/26, CNA #1 should not have left the day area to work alone in a resident room. They stated CNA #1 should have asked someone to watch the day area while they assisted the other resident. The administrator stated they have a system where the nurse on the unit and a float nurse aide would watch the day areas so other work could be completed. They stated in this instance CNA #1 had not followed their system for covering the units.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure the OSDH and a local law enforcement agency were notified of allegations of abuse within two hours of the allegations becoming known to the facility for 2 (#3 and #64) of 3 sampled residents reviewed for abuse.The administrator identified 58 residents resided in the facility.Findings:A facility policy titled Abuse, Neglect and Exploitation, dated 01/2024, read in part, In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or (sic) resident property, are reported immediately, but now later than 2 hours after the allegation is made, if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protected service where state law provides for jurisdiction in long-term care facilities) in accordance with State law.An incident report for Res #3, with an incident date of 08/19/25, showed an allegation of sexual abuse had been reported to staff by Res #3 on 08/19/25. The attached fax sheet showed the incident report was faxed to the OSDH on 08/20/25 at 2:11 p.m. The incident report showed a law enforcement agency had been contacted about the allegation on 08/20/25 at 11:30 a.m.An incident report for Res #64, with an incident date of 05/16/26, showed Res #64 had been thrown to the ground by Res #24 on 05/16/26. The attached fax sheet showed the incident report was faxed to the OSDH on 05/17/26 at 4:09 p.m. The incident report showed a law enforcement agency had been contacted about the incident on 05/17/26 at 1:50 p.m.On 06/02/26 at 3:10 p.m., the administrator stated they were the facility's abuse coordinator, but the incident reports were written and sent to the OSDH by other staff members. The administrator stated the facility had not sent in the reports to OSDH and law enforcement within two hours as required in the two instances.