

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/02/2026
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)		
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 not 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
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure they had a full-time DON for 8 of 30 dates reviewed for the employment of a DON. The administrator identified 58 residents resided in the facility. Findings: An email sent to the facility administrator from the former DON, dated 05/25/26 at 4:11 p.m., showed the facility's DON resigned effective that date. On 05/29/26 at 10:20 a.m., the administrator stated the facility did not have a full-time DON. They stated they did not have anyone who had accepted the responsibilities of the DON position. The administrator stated the former DON had resigned on Monday, 05/25/26 via an email. The administrator stated they had not been able to find a full-time or interim DON since 05/25/26. On 06/02/26 at 3:18 p.m., the administrator stated they had not found anyone to assume the duties of the DON. The administrator stated they were unable to locate a policy regarding the employment of a DON.		

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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.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure drugs and biologicals were kept at proper temperatures in 1 of 1 medication refrigerator. The administrator identified 58 residents resided in the facility. Findings: On 06/02/26 at 11:33 a.m., the medication refrigerator was observed for proper temperature control. The only temperature logs observed were from 2025. There was no temperature log observed for 2026. On 06/02/26 at 11:42 a.m., the ADON stated they had never completed the temperature log or checked the temperature of the refrigerator, and they did not know who was responsible for that task. On 06/02/26 at 3:26 p.m., the administrator stated checking the medication refrigerator temperature and maintaining the temperature logs was a nursing task, but ultimately, they were responsible to ensure tasks were completed. The administrator stated they were uncertain when the task stopped being completed or why. The administrator stated they did not have a policy for medications which require refrigeration.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure influenza and pneumococcal vaccinations were provided for 2 (#8 and #10) of 5 sampled residents reviewed for immunizations. The ADON identified 24 residents were admitted to the facility from 10/31/25 through 03/31/26. Findings: A policy, titled Infection Control Immunizations, dated 03/20/24, read in part, 1. Prior to receiving vaccinations, the resident or legal representative will be provided with information and education regarding the benefits and potential side effects of the vaccinations. 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission. 1. A quarterly MDS assessment, dated 04/22/26, showed Res #10 was admitted on [DATE] and had a BIMS score of 4 (a BIMS score of 4 indicated the resident's cognition was severely impaired). A review of Res #10's EMR showed no documentation the influenza vaccine or pneumococcal vaccine had been offered or given. 2. A quarterly MDS assessment, dated 05/11/26, showed Res #8 admitted on [DATE] and had a BIMS score of 14 (a BIMS score of 14 indicated the resident's cognition was intact). A review of Res #8's EMR showed no documentation the influenza vaccine or pneumococcal vaccine had been offered or given. On 05/28/26 at 3:02 p.m., the ADON stated the immunization section for Res #8 and #10 in the EMR was not completed and there was no documentation to show if the residents were offered the influenza vaccine or the pneumococcal vaccine. On 05/28/26 at 3:15 p.m., the ADON stated they did not offer the influenza vaccine to the new admits if they admitted after the facility had completed their annual influenza clinic. The ADON stated the facility's influenza clinic was typically in October of every year.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on record review and interview, the facility failed to ensure the COVID-19 vaccine was provided for 2 (#8 and #10) of 5 sampled residents reviewed for immunizations. The ADON identified 24 residents were admitted to the facility from 10/31/25 through 03/31/26. Findings: 1. A review of Res #8's EMR showed no documentation that any immunizations had been provided to the resident. 2. A review of Res #10's EMR showed no documentation that any immunizations had been provided to the resident. A policy titled Infection Control Immunizations, dated 03/20/24, read in part, 1. Prior to receiving vaccinations, the resident or legal representative will be provided with information and education regarding the benefits and potential side effects of the vaccinations. 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission. On 05/28/26 at 3:02 p.m., the ADON stated they had reviewed the EMR's for Res #8 and Res #10 and had no documentation the residents had been offered or administered the COVID-19 vaccination.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure an antipsychotic medication was not prescribed for the diagnosis of dementia and ensure an as needed anxiety medication order had a 14-day limit for 1 (#5) of 5 sampled residents reviewed for unnecessary medications. The ADON identified 24 residents were prescribed antipsychotic medications. Findings: A medication order for Res #5, dated 04/16/25, showed the resident was prescribed Seroquel (an antipsychotic medication) 50 mg one tablet by mouth at bedtime for dementia and behaviors. A medication order for Res #5, dated 10/09/25, showed the resident was prescribed diazepam (an antianxiety medication) 5mg/ml oral concentrate give 0.5 ml by mouth every four hours as needed for anxiety. The medication order did not have a discontinue date. A pharmacy consult report for Res #5, dated 10/30/25, showed Res #5's physician was informed psychotropic medication prescribed to be used as needed was required to have a 14-day limit unless the physician gave a written rationale for a longer limit. The consult report did not show a written response from the physician. A MAR for Res #5, dated 05/01/26 through 05/31/26, showed Res #5 was administered 24 doses of Seroquel 50 mg tablets during the month of May 2026. The MAR showed Res #5 had an order for diazepam 5mg/ml oral concentrate give 0.5 ml by mouth every four hours as needed for anxiety. On 06/01/26 at 11:19 a.m., the ADON stated they were familiar with antipsychotic medications. The ADON stated they did not know if antipsychotic medications were approved for the treatment of dementia. The ADON stated Res #5 was prescribed Seroquel because they kicked and squeezed the hands of the staff. On 06/01/26 at 11:29 a.m., the ADON stated Res #5's as needed diazepam medication order should have been limited to 14 days. On 06/02/26 at 3:10 p.m., the administrator stated the nursing department needed to review the medication orders more closely to find these types of issues.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a care plan was revised after multiple incidents of aggression toward others for 1 (#24) of 3 sampled residents reviewed for abuse. The administrator identified 58 residents resided in the facility. Findings: A Care Plan Process policy, dated 09/2019, read in part, A care plan will: Incorporate identified problem areas. A care plan for Res #24, dated 03/31/26, read in part, BEHAVIORS/WANDERING: The resident has behaviors, takes food off other residents (sic) plates, reaches over counter (sic) to get things, doesn't care to be redirected, wanders around on the unit, etc. The care plan showed no interventions related to aggression toward others. An admission assessment, dated 04/02/26, showed Res #24 had a BIMS score of 6 (the 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. A Mood/Behavior note, dated 04/15/26 at 6:24 p.m., showed Res #24 had lunged at a staff member when they were not allowed to eat from another resident's plate. A Mood/Behavior note, dated 04/17/26 at 6:23 p.m., showed Res #24 threatened to physically assault a CNA when the staff member removed a cupcake from the resident. A General note, dated 05/12/26 at 4:22 p.m., showed Res #24 was asked to remove their hand from their pants by a staff member. The note showed Res #24 responded by moving within inches of the staff member's face and asking them if they wanted to fight. A Mood/Behavior note, dated 05/13/26 at 9:57 a.m., showed Res #24 was observed lunging at another resident and a staff member had to stand between the residents. The note showed Res #24 was asked to put on clothes by another resident and Res #24 stated to that resident they would physically assault them. An Incident note, dated 05/16/26 at 4:05 p.m., showed Res #24 was observed aggressively shoving another resident to the floor. On 06/01/26 at 1:09 p.m., MDS Coordinator #1 stated they revised the care plan anytime a resident had a change in their condition such as falls, use of antibiotics, or new behaviors. MDS Coordinator #1 stated they knew Res #24's aggressive behaviors toward others had occurred, but for some reason they had forgotten to enter them into the resident's care plan. MDS Coordinator #1 stated they should have revised Res #24's care plan with a focus on aggression and new interventions. On 06/02/26 at 10:34 a.m., CNA #2 stated they had worked with Res #24 since the resident was admitted in March 2026. CNA #2 stated they had not seen Res #24 physically assault anyone but did witness the resident verbally threaten staff and other residents multiple times. They stated they reported those incidents to the nurse on duty. On 06/02/26 at 1:48 p.m., CMA #1 stated they worked with Res #24 routinely since the resident was admitted. CMA #1 stated they had observed Res #24 be verbally abusive toward residents and staff. They stated they reported those incidents to the charge nurses. On 06/02/26 at 3:11 p.m., the administrator stated the MDS coordinator should have created new interventions regarding Res #24's aggressive behaviors.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to complete an annual performance review for 1 (CNA #3) of 2 sampled CNAs reviewed for performance reviews. The current staff roster identified 13 CNAs were employed. Findings: The facility was unable to provide the 2025 annual competency for CNA #3 hired on 01/28/24 as identified by CNA #3's employee application. On 06/02/26 at 3:26 p.m., the administrator stated completing annual performance reviews was the DON's responsibility, but the facility was having a hard time keeping a DON. The administrator stated the facility did not have a policy regarding competencies, but they knew the regulations required annual competencies to be completed.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure a monthly pharmacy review was conducted for 1 (#5) of 5 sampled residents reviewed for unnecessary medications. The ADON identified 55 residents received medications in the facility. Findings: A MAR for Res #5, dated 01/01/26 through 01/31/26, showed the resident was prescribed 12 medications including aspirin, Celexa, metoprolol, Remeron, Seroquel, apixaban, acetaminophen, and diazepam. On 06/01/26 at 11:29 a.m., the ADON stated they reviewed Res #5's pharmacy consultant reports and were unable to find the January 2026 monthly pharmacy review form. On 06/02/26 at 3:10 p.m., the administrator stated the nursing department was to ensure the pharmacy reviews were completed.		