STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375421	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Country Care Center	3601 North Columbia Tulsa, OK 74110

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective 03/10/26 at 4:00 a.m. related to the facility's failure to ensure a resident with moderately impaired cognition and history of elopement did not elope unnoticed from the facility.On 03/19/26, the Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to prevent a resident's elopement.The past noncompliance IJ was removed effective 03/10/26 at 1:30 p.m., when the facility had put the following measures in place to prevent recurrence.a. On 03/10/26 the administrator contacted the QAPI committee members and created a performance improvement plan which included continued inspections of points of possible egress from the facility, staff education on elopement was initiated, continued 1:1 monitoring of Res #1 until discontinued by their physician, and ongoing monitoring of elopement prevention procedures by the administration and QAPI committee.b. On 03/10/26 the maintenance supervisor inspected the locks and code pads to all doors that lead to the outside of the building. They also checked to ensure each window remained locked and secure from being opened by residents. c. On 03/10/26 at 9:36 a.m. the resident was placed on 1:1 monitoring for high elopement risk.d. On 03/10/26 at 1:30 p.m. the facility completed mandatory staff training on elopement prevention for a 31 staff. Staff participation was verified through training sign in sheets and interviews. Based on record review and interview, the facility failed to ensure a resident did not elope from the facility for 1 (#1) of 3 sampled residents reviewed for elopement.The administrator stated that 81 residents resided at the facility.Findings:An undated facility policy, titled, Elopements, showed the facility had a five-point plan regarding elopement prevention, reporting, searching, and care of residents after return to the facility.A face sheet from a community acute care hospital, dated 02/20/26, showed the hospital had sent Res #1 to a nursing facility where they quickly eloped. The document further showed the nursing facility then refused to accept the resident and sent Res #1 back to the hospital.A social services admission evaluation, dated 03/04/26, showed a family member had stated they were happy Res #1 was in a locked memory care facility as they were an elopement risk.An incident report form (ODH form 283), incident date 03/10/26, showed that on 03/10/26 at approximately 6:20 a.m., facility staff discovered they could not locate Res #1. The incident report further showed that at approximately 8:40 a.m., Res #1 was found in the community near a local public school (the school is located approximately 2.2 miles from the facility).An admission assessment, dated 03/11/26, showed Res #1 had been admitted to the facility on [DATE] with diagnoses which included non-traumatic brain disfunction and dementia. The resident's BIMS (a test of cognitive functioning) score of 9 showed the residents' cognition was moderately impaired.On 03/18/26 at 10:33 a.m., family member #1 stated Res #1 had previously eloped from another nursing home prior to being admitted to the facility. They stated the resident had memory problems stemming from a motor vehicle accident. They also stated in another incident Res #1 had been hit by a car while walking in the community. Family Member #1 stated they had made staff aware of the resident's history during the admission process.On 03/19/26 at 8:17 a.m., LPN #1 stated they had found out about Res #1 being missing from LPN #2 on 03/10/26 at 8:00 a.m. They (continued on next page)

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
	375421	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Country Care Center	3601 North Columbia Tulsa, OK 74110

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated the resident was returned to the facility by a staff member later in the morning at about 9:30 a.m. LPN #1 stated they assessed the resident when they returned and found no injuries.On 03/19/26 at 8:46 a.m., CNA #1 stated they had clocked into work at approximately 6:52 a.m. and just prior to 7:00 a.m., they went to Res #1's room. They stated they did not find the resident in their room, and they and LPN #2 searched the building and surrounding area but did not locate the resident. CNA #1 stated they had gone back to Res #1's room to check again. They stated when they checked the window it was still secured and the window screen was in place. They stated they did not know how the resident got out of the building.On 03/19/26 at 11:18 a.m., CNA #2 stated the last time they had observed Res #1 on 03/10/26 was at approximately 4:00 a.m., during their last rounds of the night shift.On 03/19/26 at 11:25 a.m., LPN #3 stated the last time they observed Res #1 on 03/10/26 was approximately 3:30 a.m. during the night shift.On 03/19/26 at 1:24 p.m., the SW stated during admission they did not hear about the resident's elopement history from Res #1's family but from later reading hospital records. They stated the day after learning of the elopement history they had informed the nursing staff during the morning meeting. They stated they had not documented learning about the elopement history or that they had alerted the staff but was sure they would have notified staff. On 03/19/26 at 1:50 p.m., the administrator stated they had not been able to definitely identify how Res #1 had eloped from the facility, but they had taken steps to ensure the staff was vigilant in regards to resident safety. They stated they had ensured that all exits would continue to be inspected with resident security and safety in mind.