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	11/15/2024

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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 41220 Based on observation and interview, the facility failed to provide access to notifications of resident rights, ombudsman contact information, and state agency contact information. The administrator identified 76 residents resided in the facility. Findings: On 11/13/24 at 10:41 a.m., the five residents who attended the resident council meeting stated they did not know where to find the phone number to contact the ombudsman, did not know where the resident rights were posted, or how to contact OSDH to register a complaint or concern. Immediately following the resident council meeting, the notices were observed to be posted in the locked vestibule by the facility front door, and inside the nurses' station along the far wall. The locked vestibule was not accessible by the residents. The notices inside the nurses' station were not readable from the hallway. On 11/13/24 at 11:41 a.m., the administrator stated the ombudsman's phone number, resident rights, and state department phone numbers were posted in the vestibule and by the back nurses' station. The administrator stated the information in the vestibule was not accessible by residents, but was visible for family. The administrator stated residents were not permitted inside the nurses' station and the notices were not readable from outside the nurses station.

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: 375421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Green Country Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 North Columbia Tulsa, OK 74110	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46703 Based on record review and interview, the facility failed to provide information to formulate an advance directive for three (#22, 66, and #71) of three sampled residents who were reviewed for advance directives. The administrator identified 75 residents who resided in the facility. Findings: The Advance Directives policy, dated December 2016, read in part, Upon admission, the resident will be provided with written information concerning the right .to formulate an advance directive if he or she chooses to do so .the information may be provided to the resident's legal representative .The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. 1. Resident #22 was admitted to the facility on [DATE]. No acknowledgement form for an advance directive was in the resident's electronic record. 2. Resident #71 was admitted to the facility on [DATE]. No acknowledgement form for an advance directive was in the resident's electronic record. On 11/14/24 at 11:45 a.m., the admissions coordinator stated they did not have documentation an advance directive was offered to Resident #22 and Resident #71. 35474 3. Resident #66 had diagnoses which included dementia. Review of the electronic clinical record documented the resident was a full code status. Documentation of information provided to the resident/resident representative for formulation of an advance directive was not available in the electronic clinical record. On 11/14/24 at 11:41 a.m., the admissions coordinator stated they were unaware they needed to document that residents had been offered advance directives. They stated the family for Resident #66 wanted the resident's code status to be a full code, but discussion regarding the formulation of an advance directive had not been documented. On 11/15/24 at 10:11 a.m., the administrator stated the admission packet contained information for the resident/resident representative regarding formulating an advance directive. On 11/15/24 at 10:18 a.m., the administrator stated they did not have documentation an advance directive had been discussed with Resident #66 or their representative.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35474 Based on record review and interview, the facility failed to ensure advance beneficiary notices had been provided for two (#22 and #47) of three sampled residents reviewed for beneficiary notices. The Entrance Conference Worksheet documented ten residents who remained in the facility with skilled days remaining in the past six months. Findings: 1. Resident #22 had diagnoses which included dementia. The SNF Beneficiary Notification Review form, completed by the facility, documented the resident's last covered day of Part A services was 06/13/24, the facility initiated the discharge from skilled services, and an ABN had not been provided. The undated NOMNC, provided by the facility, documented the resident/resident representative had been notified of the change in services on 06/12/24. Review of the electronic clinical record revealed the resident remained in the facility long term care after skilled services had ended. 2. Resident #47 had diagnoses which included dementia. The SNF Beneficiary Notification Review form, completed by the facility, documented the resident's last covered day of Part A services was 08/29/24, the facility initiated the discharge from skilled services, and an ABN had not been provided. The undated NOMNC, provided by the facility, documented the resident/resident representative had been notified of the change in services on 08/29/24. Review of the electronic clinical record revealed the resident remained in the facility for long term care after skilled services had ended. On 11/15/24 at 10:06 a.m., the admissions coordinator stated they only provided the NOMNC when residents were discharged from skilled services. They stated they were notified to make the resident/resident representative aware of the change in services 48 hours in advance. They stated they had verbally notified the representatives for both Resident #22 and Resident #47, but had not documented the notification. On 11/15/24 at 10:10 a.m., the administrator stated the facility had missed providing the ABNs and training was needed for beneficiary notices.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure assessments were encoded and transmitted for one (#128) of one sampled resident reviewed for assessments. The administrator identified 76 residents who resided in the facility. Findings: Resident #128 had diagnoses which included dementia. A discharge return anticipated assessment, dated 09/10/24, documented the resident had discharged from the facility. A progress note, dated 09/11/24, documented the resident had returned from the hospital. Review of the assessments in the electronic clinical record did not reveal an entry assessment had been completed upon the resident's readmission to the facility on [DATE]. The next documented assessment in the electronic clinical record, after the discharge return anticipated assessment, was an in progress quarterly assessment dated [DATE]. On 11/15/24 at 2:03 p.m., MDS coordinator #1 stated they completed an entry assessment when a resident returned from a hospital stay. They stated the entry assessment for 09/11/24, for Resident #128, had been overlooked. On 11/15/24 at 3:21 p.m., MDS coordinator #2 stated they had reviewed the assessments for Resident #128 and noted the entry assessment for 09/11/24 had not been completed. They stated the assessment had been overlooked. They stated they utilized a tracking form to monitor discharge assessments, but did not monitor for entry/re-entry assessment completion.

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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 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. 46703 Based on observation, record review, and interview, the facility failed to update the care plan for two (#22 and #128) of two sampled residents whose care plans were reviewed. The administrator identified 76 residents resided in the facility. Findings: 1. Resident #22 had diagnoses which included dementia. A Care Plan, dated 09/05/24, documented no care areas related to skin picking. On 11/12/24 at 8:59 a.m., Resident #22 was observed with a nickel size open wound on the right side of the back of their neck and multiple small wounds on their forehead and hands. On 11/14/24 at 2:19 p.m., LPN #2 stated the resident has several places on their face and hands where they picked the skin open. LPN #2 stated the wounds scabbed over and the resident opened them again. LPN #2 stated the resident had always done this. A review of the resident's care plan did not reveal an update to include the resident picking at their skin. On 11/14/24 at 3:12 p.m., MDS Coordinator #1 stated they had updated the resident's care plan on 11/14/24, but had not included picking at the skin prior to 11/14/24. 35474 2. Resident #128 had diagnoses which included dementia. The quarterly assessment, dated 08/20/24, documented the resident rejected care one to three days during the look back period. The discharge return anticipated assessment, dated 09/10/24, documented the resident required supervision/touch assist for bathing and toileting. The assessment documented the resident rejected care one to three days during the look back period. The CNA Shower Skin Observation Tool forms, dated 10/02/24 through 11/15/24, documented the resident had refused showers 17 times out of 22 opportunities. On 11/13/24 at 11:35 a.m., the resident was observed sitting on their bed. A urine/body odor was observed upon entering the resident's room. The Care Plan, revised 11/14/24, documented to assist the resident with bathing as needed. The care plan did not document the resident refused showers or care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 8:54 a.m., the resident was observed sitting on their bed. A urine odor was observed upon entering the resident's room. On 11/15/24 at 11:12 a.m., CNA #1 stated the resident had a history of refusing care such as showers and linen changes. On 11/15/24 at 12:51 a.m., the DON stated the resident refused showers and incontinent care at times. On 11/15/24 at 1:03 p.m., the ADON stated the resident refused showers. They stated they would try different staff, different shifts, and call the resident's family for assistance. On 11/15/24 at 4:09 p.m., MDS coordinator #1 stated they were not aware the resident refused care such as showers. They stated they had not seen documentation of refusals. On 11/15/24 at 4:11 p.m., MDS coordinator #2 stated they had not been made aware the resident refused showers so they had not updated the care plan related to the refusal of care for Resident #128.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35474 Based on observation, record review, and interview, the facility failed to ensure showers to dependent residents for one (#128) of one sampled resident who was reviewed for ADL care. The DON identified 62 residents who were dependent on staff for bathing. Findings: Resident #128 had diagnoses which included dementia. The quarterly assessment, dated 08/20/24, documented the resident required set up assistance for showers and rejected care one to three days during the look back period. The discharge return anticipated assessment, dated 09/10/24, documented the resident required supervision/touch assist for bathing and toileting. The assessment documented the resident rejected care one to three days during the look back period. The CNA Shower Skin Observation Tool forms, dated 10/02/24 through 11/15/24, documented the resident had refused showers 17 times out of 22 opportunities. The form documented, Refused? Intervention to prevent recurrence? The area for documentation of intervention to prevent recurrence was left blank on all 17 documented refused showers. On 11/13/24 at 11:35 a.m., the resident was observed sitting on their bed. A urine/body odor was observed upon entering the resident's room. The Care Plan, revised 11/14/24, documented to assist the resident with bathing as needed. The care plan did not document the resident refused showers or care. On 11/14/24 at 8:54 a.m., the resident was observed sitting on their bed. A urine/body odor was observed upon entering the resident's room. On 11/15/24 at 11:12 a.m., CNA #1 stated the resident had a history of refusing care such as showers and linen changes. CNA #1 stated the odor in the resident's room was because at times the resident urinated near, but not in the toilet, the resident refused showers, and refused linen changes. CNA #1 stated at times they would call the resident's family member for assistance with ADL care. On 11/15/24 at 12:51 a.m., the DON stated the resident wanted to be more independent than possible due to a visual impairment. The DON stated the resident refused showers and incontinent care and they notified the family for assistance. On 11/15/24 at 1:03 p.m., the ADON stated the resident refused showers. They stated they would try different staff, different shifts, and call the resident's family for assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 4:21 p.m., the DON stated they were not aware Resident #128 had refused as many showers as they had since 10/02/24. The DON stated the ADON was responsible to monitor the hall the resident resided on to ensure ADL care had been received. On 11/15/24 at 4:41 p.m., the ADON stated the charge nurse and themselves were responsible to review the shower sheets to ensure residents were receiving ADL assistance. They stated if refusals were documented on the shower sheet interventions would need to be implemented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 35474 Based on observation, record review, and interview, the facility failed to ensure medications were dated when opened for one (North hall medication cart) of two medication carts observed. The DON identified four medication carts in the facility. Findings: On 11/15/24 at 3:56 p.m., the North hall medication cart was observed with LPN #1. The following medications were observed to be open, but not dated. a. neomycin/polymyxin 0.1% eye drops for Resident #126; b. fluticasone nasal spray 50mcg for Resident #47; c. fluticasone nasal spray 50mcg for Resident #11; and d. fluticasone nasal spray 50mcg for Resident #14. On 11/15/24 at 3:58 p.m., LPN #1 stated they were to date nasal sprays and eye drops when they were opened. On 11/15/24 at 4:21 p.m., the DON stated they were to date nasal sprays and eye drops when they were opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46703 Based on observation and interview, the facilty failed to ensure infection control was maintained during feeding assistance for one (#55) of one sampled resident observed for meal assistance. The administrator identified 20 residents dependent on staff for meal assistance. Findings: On 11/12/24 at 12:09 p.m., LPN #1 was observed assisting Resident #55 with the noon meal. LPN #1 was observed to blow on a spoonful of food before placing it in Resident #55's mouth. On 11/12/24 at 12:12 p.m., LPN #1 stated to maintain infection control they should not blow on a resident's food. On 11/15/24 at 4:30 p.m., the DON stated if food was hot the staff were to let it cool down before feeding it to residents. The DON stated staff should not blow on residents' food.