

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Greenbrier Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1119 East Owen K Garriott Road Enid, OK 73701	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>47453</p> <p>Based on record review and interview, the facility failed to notify a resident's responsible party when the resident had a fall for one (#1) of three sampled resident reviewed for falls.</p> <p>The Administrator identified 80 residents resided in the facility.</p> <p>Findings:</p> <p>A Doctor Calls form, undated, read in part, Assess residents for change in condition, disease processes, notify physicians and family.</p> <p>Resident #1 had diagnosis which included arterial fibrillation, acute respiratory infection, congestive heart failure.</p> <p>A progress note, dated 06/02/24 at 1:30 p.m., documented Resident #1 was on the floor in room, on their side with a skin tear to right elbow. The note did not document if the resident's representative was notified of the fall.</p> <p>On 10/08/24 at 10:33 a.m. The DON stated They stated they had reviewed Resident #1's progress note from 06/02/24 and did not find documentation anyone at the facility had notified the emergency contacts listed in Resident #1's chart.</p> <p>On 10/08/24 at 11:21 a.m., LPN #1 was asked the policy for contacting family and/or resident representative for change of condition and/or fall. They stated that family is to be notified of all incidents. They were then asked to review a progress note for a fall on 06/2/24 for Resident #1, after review they were asked if family and/or resident representative was notified of the fall on 06/02/24, they stated the progress note does not state if family was notified of fall.</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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