STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375353	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Village Health and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify a family member of a resident's fall for 1 (#107) of 3 sampled residents reviewed for notification of falls. The DON identified 99 residents resided at the facility. Findings: A policy titled Change in a Resident's Condition or Status, dated 12/2025, read in part, A nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury. A comprehensive admission assessment for Resident #7, dated 02/03/26, showed the resident was admitted on [DATE] for therapy services. A facility incident report, dated 02/12/26, showed Resident #107 fell on [DATE] at 4:27 p.m., obtained a large bruise, and a laceration which measured 1.75 cm over their right eye. There was no documentation Resident #107's family was informed until 02/13/26. On 06/24/26 at 10:23 a.m., a family member of Resident #107 stated they came to the facility on [DATE] at approximately 1:00 p.m., to visit Resident #107 when they noticed bruising and a laceration to the resident's right eye. They stated they were not informed of the fall Resident #107 experienced the day before. On 06/25/26 at 9:59 a.m., the ADON stated a fall which resulted in a laceration would be considered an emergency if the injury required stitches. On 06/25/26 at 10:01 a.m., the clinical VP stated they would attempt to notify the family immediately. They agreed the family should have been notified on 02/12/26, when the fall occurred.

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, record review, and interview, the facility failed ensure 2 staff members were utilized to transfer a resident with a mechanical lift placing the resident at risk for falls for 1 (#65) of 5 sampled residents reviewed for falls. The DON identified 27 residents required the use of a mechanical lift for transfers.Findings: On 06/23/26 at 7:35 p.m., Resident #65 was observed sitting in a geriatric chair in the common area between the [NAME] and [NAME] halls. On 06/23/26 at 7:51 p.m., CNA #2 was observed to walk out of Resident #65's room with the mechanical lift. CNA #2 was observed to have been in the room alone and had transferred Resident #65 to the bed from their geriatric chair. A Using a Mechanical Lifting Machine policy, dated 07/01/17, read in part, At least two nursing assistants are needed to safely move a resident with a mechanical lift. A care plan intervention for Resident #65, dated 02/15/26, read in part, Per physical therapy for safety, the resident is only to be transferred using a mechanical full-body lift. A quarterly assessment for Resident #65, dated 04/01/26, showed the resident required substantial/maximal assistance from staff for transfers. The assessment showed the resident's cognition was severely impaired with a BIMS score of 2. The assessment showed the resident had a diagnosis of dementia and a history of falls. On 06/21/26 at 11:55 a.m., family member #1 stated on 06/17/26, one staff member attempted to transfer Resident #65 by themselves using a mechanical lift, while the family member and hospice nurse were in the room with the resident. Family Member #1 stated the hospice nurse intervened because they knew two staff members were supposed to use the mechanical lift for safety. Family Member #1 stated the facility did not have enough staff to safely transfer residents who required a mechanical lift. On 06/23/26 at 3:28 p.m., CNA #2 stated they were very short-staffed on the 2 p.m. to 10 p.m. shift, and that made it hard to transfer residents who required two staff members for assistance. CNA #2 stated they were not allowed to use a mechanical lift without two staff members. On 06/23/26 at 3:30 p.m., CNA #3 stated they had been told to transfer a resident using a mechanical lift by themselves because no other staff was available. CNA #2 stated they refused to transfer a resident who was a two-person assist alone because it was not safe. On 06/23/26 at 3:53 p.m., CNA #4 stated they previously had to transfer a resident alone using a mechanical lift because no other staff was available. On 06/23/26 at 7:52 p.m., CNA #2 stated they had transferred Resident #65 by themselves using the mechanical lift because the other aide had to take a phone call and no other staff was available to help. On 06/23/26 at 8:15 p.m., the DON was asked if a staff member should transfer a resident by themselves with a mechanical lift. The DON stated absolutely not. The DON stated two staff members were required when using a mechanical lift.