

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: 375353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Greenbrier Village Health and Rehabilitation		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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure furniture in the memory care unit was kept clean, maintained in good repair, and reflected a home-like environment. The DON identified 17 residents resided in the memory care unit. Findings: On 07/20/26 at 6:13 a.m., eight recliners were observed in the common area of the memory care unit which had small tears and small cracks on each arm of each recliner. On 07/20/26 at 6:20 a.m., two couches in the dining area of the memory care unit were observed to have multiple dark stains. The couch on the right was observed to have a large slit in the upholstery exposing the cushion inside. On 07/27/26 at 12:21 p.m., CMA #1 stated the couches in the dining area were worn, stained, the one on the right had a large slit in the fabric, and they should be replaced. On 07/27/26 at 12:25 p.m., licensed practical nurse #3 stated the eight recliners were not in good condition. They stated it would be better if each arm of each chair did not have cracks in them. On 07/27/26 at 12:26 p.m., CMA #1 stated the eight recliners in the common area were worn, with tears in all arms of each chair. They stated they should at least be recovered. On 07/27/26 at 4:17 p.m., the infection preventionist stated the stained couches should be deep cleaned, covered, and attempt to repair the split fabric on the couch on the right.		

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect the resident's right to be free from sexual abuse for 1 (#2 and #3) of 3 sampled residents reviewed for sexual abuse. The DON identified 17 residents resided in the memory care unit. Findings: A policy titled Suspected or Allegation of Resident Abuse/Neglect/Misappropriation of Property and Involuntary Seclusion, dated 06/2019, read in part, All employees .and visitors by law are to report allegations of and/or abuse .Sexual Abuse/Sexual Assault .lewd and indecent acts. 1. A nurse's note for Resident #1, dated 05/01/26, showed the resident admitted to the memory care unit. An admission assessment for Resident #1, dated 05/01/26, showed the resident had a BIMS score of 1, which indicated severely impaired cognition. A care plan for Resident #1, dated 05/02/26, showed the resident needed cueing, reorientation, and supervision as needed. A care plan for Resident #1, dated 05/08/26, showed the resident had mood, behaviors, delusional disorder to include wandering the hall, hitting staff, and a history of inappropriate touch. Interventions listed included to intervene as necessary to protect the rights and safety of other residents, if reasonable, discuss the resident's behavior explaining why the behavior was inappropriate or unacceptable, and monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential issues. A care plan for Resident #1, dated 05/12/26, showed the resident was to be provided with line of sight during times of agitation. A care plan for Resident #1, dated 05/13/26, showed the resident was referred to geri psych as indicated for escalated behaviors and medication management. A care plan for Resident #1, dated 05/27/26, showed the resident returned from geri psych and to encourage a calm, quiet environment, redirect from common areas during agitation. Approach calmly, from the front, do not surprise the resident. A care plan for Resident #1, dated 07/02/26, showed the resident used psychotropic medications related to behavior management. Interventions included to monitor, record occurrence for target behavior symptoms, pacing, wandering, inappropriate response to verbal communication, violence/aggression toward staff/others, and document per facility protocol. A progress note for Resident #1, dated 07/14/26, showed RN #2 reported they witnessed Resident #1 sitting close to Resident #2 and touching them inappropriately. A hospice visit note for Resident #1, dated 07/14/26, showed Resident #1 was in the dining room standing over Resident #2 who was seated with their hands on their chest, abdomen, and groin area. RN #2 attempted to redirect Resident #1. Resident #1 grabbed the face of Resident #2 and began kissing them. Resident #1 was redirected. Resident #1 stood behind Resident #2 and placed their hands in their hair. The residents were separated and Resident #1 was redirected toward their room. A police report, dated 07/14/26, showed Resident #1 forcibly kissed Resident #2. Resident #1 was being really touchy and touched Resident #2 on the breast and all over their body. Staff told Resident #2 to get away from Resident #1, but they looked shocked and stuck. Until staff were called and went with them, Resident #1 was taken to their room and being watched. A progress note for Resident #1, dated 07/17/26, read in part, [Resident #1] was accepted to inpatient geri psych with a bed available today. 2. A census list for Resident #2, dated 04/03/26, showed the resident admitted to the memory care unit. A medical diagnoses tab in the EHR for Resident #2, dated 04/14/26, showed the resident had diagnoses which included Alzheimer's, dementia, disorientation, and psychosis. A medical diagnoses tab in the EHR for Resident #2, dated 05/08/26, showed Resident #2 had a diagnosis of altered mental status. A quarterly assessment for Resident #2, dated 07/17/26, showed the resident could ambulate independently without a device. The assessment showed Resident #2 had a BIMS (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 6 which indicated moderately impaired cognition. On 07/27/26 at 2:18 p.m., RN #2 stated they observed Resident #1 with their hands on Resident #2 over their clothing in the groin area. They stated the face of Resident #2 looked distraught. Resident #1 placed their hands on Resident #2 from the groin area, abdomen, chest. RN #2 stated When they tried to gain the attention of Resident #1, they grabbed the face of Resident #2 and kissed their face. On 07/27/26 at 4:05 p.m., the power of attorney for Resident #2 stated they had been notified and they were relieved Resident #1 was no longer at the facility. 3. A medical diagnoses tab in the EHR for Resident #3, dated 07/11/25, showed the resident had a diagnosis of dementia. A care plan for Resident #3, dated 07/28/25, showed the resident was at risk for altered cognition related to dementia, depression, infection, and multiple sclerosis. The care plan showed the resident has a BIMS score was 11 on admission which indicated moderate impaired cognition. The care plan showed the resident required curing for short term memory recall. A census list for Resident #3, dated 06/30/26, showed the resident transferred to the memory care unit. A wandering risk scale assessment for Resident #3, dated 06/30/26, showed the resident was a high risk to wander. A final incident report, dated 07/02/26, showed an allegation of abuse reported by Resident #3 about Resident #1 going into their room at night and grabbing their breast. A police report, dated 07/02/26, showed Resident #3 advised Resident #1 had entered their room late one night and Resident #1 put their hand near their breast on their shoulder. The report showed Resident #3 stated they told Resident #1 to leave, and Resident #1 muttered something to themselves and left. The report showed Resident #3 advised they believed the incident was accidental and Resident #1 was confused. A progress note for Resident #3, dated 07/18/26, showed the resident was transferred to the hospital after a fall for evaluation and treatment. A progress note for Resident #3, dated 07/19/26, showed the resident had been admitted to the hospital for a right ankle fracture with the possibility of surgery same day. On 07/22/26 at 11:39 a.m., the DON stated they increased staff on the memory care unit from two staff to three staff to monitor resident behaviors. On 07/22/26 at 11:44 a.m., the DON stated resident behaviors were tracked by the IDT daily, but there was no documentation of the behavioral findings or tracking of the IDT. The DON stated it was necessary to discuss resident behaviors and updated their care plans.		