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	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Nursing Home	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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure:a. ongoing side effects and behavior monitoring were completed for residents on psychotropic medications for 4 (#2, 9, 26, and #28); andb. a PRN order for psychotropic medication was limited to 14 days for 2 (#9 and #28) of 4 sampled residents reviewed for unnecessary medication review.The administrator identified 62 residents received psychotropic medications resided in the facility.Findings:An undated facility policy Behavior and Psychotropic Drug Use, read in part, Anytime PRN antianxiety medication is given, Nurses Note must be placed in [system name withheld] under behavior Note. Medication follow up. All behaviors will be documented in a behavior note .Behaviors will be monitored by charge nurse and documented in [system name withheld] by exception under behavior notes . Physician evaluation to be completed every 14 days for any PRN psychotropic medications .Ongoing monitoring is essential to evaluate the effectiveness of the medication, identify potential adverse reactions, and ensure patient safety.1. A care plan, dated 04/29/25, showed Resident #2 had diagnoses which included generalized anxiety disorder and unspecified depression. The care plan showed to monitor for non-verbal signs and symptoms of depression: sadness, anxiety, and distress. Administer medication as ordered, monitor for effectiveness/side effects.A physician's order, dated 06/02/25, showed buspirone HCl (antianxiety medication) 5 mg, give one tablet by mouth two times a day related to generalized anxiety disorder.A physician's order, dated 06/02/25, showed Duloxetine HCl (antidepressant medication) capsule delayed release particles 60 mg give one capsule by mouth at bedtime related to generalized anxiety disorder. Review of the June 2025 medication administration record showed Resident #2 received the above medications as ordered.There was no order for side effects monitoring for the use of psychotropics.There was no documentation behavior and side effects monitoring for the use of psychotropics was completed from 06/02/25 to 07/03/25.2. Resident #26's physician's order, dated 02/26/25, showed clonazepam (anticonvulsant medication) 0.5 mg, give 0.5 tablet by mouth at bedtime related to unspecified anxiety disorder.A physician's order, dated 02/26/25, showed Mirtazapine (antidepressant medication) 30 mg, give one tablet by mouth at bedtime related to unspecified insomnia.A physician's order, dated 03/20/25, showed Wellbutrin SR (sustained release) (antidepressant medication) extended release 12 hours 150 mg, give one tablet by mouth one time a day related to unspecified recurrent major depressive disorder.A physician's order, dated 06/07/25, showed Effexor (antidepressant medication) extended release 24 hours 150 mg, give one capsule by mouth one time a day related to unspecified recurrent major depressive disorder.A care plan, revised 06/10/25, showed Resident #26 had diagnoses which included personal history of other mental and behavioral disorders, unspecified recurrent major depressive disorder, unspecified anxiety disorder, and unspecified insomnia. The care plan showed Resident #26 was at risk for side effects related to daily use of psychotropic medications and to monitor and document side effects.A physician's order, dated 06/12/25, showed risperidone (antipsychotic) 0.5 mg, give one tablet by mouth two times a day related to personal history of other mental and behavioral disorders. A review of Resident #26's medication administration record for April, May, and June 2025 showed the resident received the above medications as ordered.There was no order for side effects monitoring for the use of psychotropics.There was no documentation ongoing side effects monitoring for the use of psychotropics was completed from 04/01/25 through 06/30/25.The behavior notes documented from 04/01/25 through 07/03/25 were on the following days:a. 04/28/25 at 21:13 [9:13 p.m.],b. 06/13/25 at 16:35 [4:35 p.m.], andc. 06/13/25 at 16:39 [4:39 p.m.].On 07/03/25 at 9:46 a.m., the DON stated they charted behaviors and side effects by exception and intervene as needed.3. A physician's order for Resident #28, dated 08/01/23, showed Eliquis (blood thinning medication) tablet 2.5 mg, give one tablet by mouth two times a day related to atherosclerotic heart disease. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 02/26/25, showed Duloxetine HCL (antidepressant medication) capsule delayed release particles 30 mg, give one capsule by mouth two times a day related to depression.A physician's order, dated 02/26/25, showed Namenda (memory loss medication) tablet 10 mg, give one tablet by mouth two times a day related to unspecified dementia.A physician's order, dated 02/27/25, showed Risperdal (antipsychotic medication) tablet 1 mg, give one tablet by mouth two times a day related to delusional disorders. A physician's order, dated 03/14/25, showed Lorazepam Intensol (antianxiety medication) oral concentrate 2 mg/ml, give 0.25 ml by mouth every four hours as needed for anxiousness. A care plan dated, dated 06/03/25, showed Resident #28 had diagnosis which included Alzheimer's, delusional disorders, dementia, depression, atherosclerotic heart disease, and atrial fibrillation. It showed to monitor for impaired balance and cognitive function for Alzheimer's. It showed to monitor for effectiveness. It showed to monitor therapeutic effectiveness and side effects for atrial fibrillation. It showed to observe for signs and symptoms of delirium and to observe for side effects of medications.Review of the March through July 2025 medication administration and treatment administration records showed Resident #28 received the medications as ordered mentioned above.There was no order for side effect monitoring or documentation for behavior and side effect monitoring for the use of psychotropics, anticoagulant, and Alzheimer's medication was completed from 03/01/25 through 07/03/25.There was no stop date or re-evaluation following 14 days for the administration of Lorazepam ordered as needed.On 07/03/25 at 9:15 a.m., LPN #3 stated Resident # 28 received the order for the Lorazepam on 03/14/25, and stated is was for 2 mg every four hours as needed. They stated the order had not been discontinued or re-written. LPN #3 stated Resident #28 received the Lorazepam as needed on 03/27/25, 04/17/25, 05/07/25, 05/12/25, and on 06/09/25. LPN #3 stated there was not a stop date.On 07/03/25 at 9:20 a.m., LPN #3 stated they did not have documentation that was a yes or no for behaviors. They just document when behaviors occur, notify, and follow orders if received and make a note.4. A Physician's Order, dated 11/26/24, for Resident #9 read, Lorazepam Intensol Oral Concentration 2 MG/ML Give 0.25 ml by mouth every 4 hours as needed for anxiousness related to generalized anxiety disorder. The end date for the Lorazepam order, read in part, Indefinite.A review of Resident #9's MAR from November 2024 through June 2025 showed Resident #9 was administered PRN Lorazepam Intensol Oral Concentration 2 MG/ML on 2/25/25, 3/13/25, 3/25/25, 3/27/25, and 5/8/25. There was no documentation of side effect monitoring.A review of Resident #9's physician progress notes on 01/16/25, 01/30/25, 05/28/25, 06/19/25, and 06/26/25 did not show an evaluation related to PRN lorazepam need or use.A Nurse' Note, dated 5/28/25, for Resident #9, read in part, This nurse contacted [physician] office to see when [they] would be out to see res RT [related to] PRN antianxiety medication order and the need to be seen Q 14 days to continue order. [Physician] staff reported due to [their] family emergency [they] would be out to see res as soon as possible but did not want to DC [discontinue] PRN lorazepam order with the knowledge of the Q 14 day rule. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Minimum Data Set, dated [DATE], showed Resident #9 admitted to the facility on [DATE] with diagnoses to include delusional disorders, psychotic disorder, anxiety, depression, pseudobulbar effect, and non-Alzheimer's dementia.On 07/01/25 at 10:09 a.m., LPN #3 was asked what behaviors Resident #9 exhibited. They stated, If there's new staff [Resident #9] doesn't like it, but [they're] mostly calm. LPN #3 was asked if Resident #9 had ever been administered Lorazepam and they stated, Yes, usually an hour before [their] shower. LPN #3 was asked if they have ever had to give PRN Lorazepam for any behaviors besides anxiousness for baths and they stated, No.On 07/02/25 at 12:41 p.m., LPN #2 was asked what Resident #9's mood and behavior was like. They stated, Mostly in a good mood, but sometimes gets upset with care. [They're] very cooperative and friendly. LPN #2 was asked how often Resident #9 was utilizing their PRN Lorazepam. They stated, Not very often. I don't think hardly ever.On 07/02/25 at 12:51 p.m., LPN #1 was asked who prescribed the PRN lorazepam for Resident #9. LPN #1 stated the name of the physician and said, To maintain it [the lorazepam] [the physician] sees [Resident #9] every 14 days.On 07/02/25 at 12:53 p. m., LPN #1was asked if there was an end date for Resident #9's PRN lorazepam. They stated, No.On 07/02/25 at 1:54 p.m., the DON was asked how the facility monitored residents for side effects of psychotropics. They stated, Quarterly on their MDS and the charge nurses and aides on the floor know who's on what. They were asked where side effect monitoring was documented and they stated, We document by exception on behavior and side effects. The DON was asked how the charge nurses and aides on the floor knew what side effects for which residents to look for. They stated, The aides don't have access to the med list, but the med aides give meds. The DON was again asked how the charge nurses and CMAs know what side effects in which residents to look for. They stated, They know what medications they're on. On 07/02/25 at 1:59 p.m., CMA #1 was asked what drugs were psychotropics. They stated, Lorazepam and I can't think of any more. CMA #1 was asked what are side effects of psychotropic drugs. They stated, They can make them [residents] sleepy. That's the one I know. CMA #1 was asked how they knew which residents took psychotropic drugs and they stated, It pops up on my computer. CMA #1 was asked where they document the monitoring for side effects of psychotropic drugs and they stated, If anything were to happen then we tell the nurse.On 07/02/25 at 2:02 p.m., LPN #2 was asked how they monitored residents for side effects of psychotropic drugs. They stated, We check and assess residents every day. They were asked where they document residents on psychotropic drugs were monitored. LPN #2 stated, In the progress note. They were asked how often they document on the monitoring of psychotropic side effects. LPN #2 stated, If it's a PRN then we document after we give it. They were asked what the facility's process was on routine psychotropic drug monitoring. They stated, If there's any side effects we see, we chart on it.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a PASARR level 1 was completed after a new mental health diagnosis for 1 (#9) of 5 sampled residents reviewed for PASARRs.The administrator identified 81 residents resided in the facility.Findings:A PASSAR Level 1, dated 06/15/21, showed Resident #9 had a primary diagnosis of cerebrovascular accident due to thrombosis and a secondary diagnosis of dementia without behaviors. A Behavior Note, dated 08/31/21, read in part, CNA told this nurse that resident was not acting [their] usual self et attempting to get out of bed by [themselves]. This nurse went to resident to assess et speak with [them] on how [they] was feeling. Resident responding with verbal aggression, body language very tensed as if [they] was going to hit this nurse. Resident demanded to get up, explained the use of hoyer lift to [them] et asked if we could assist [them] with the hoyer lift. Resident agreed. Hoyer brought into room et when res saw sling [they] became very aggressive, refused to use hoyer with sling. Sit to stand used in place of hoyer. Resident then assisted to recliner where [they] threw call light et continued with verbal aggression towards this nurse. This nurse attempted to reorient resident, listen to res about what [they] had to say, et tried to understand what was upsetting [them]. Resident c/o being tied down to bed, sheets et comforter noted to be only thing in bed at this time, et that [they] would 'NOT STAND FOR THIS!!'. This nurse offered to call res's [family] in hopes it may calm [them] down, this mad resident even more upset, PRN xanax [benzodiazepine] also offered et resident refused immediately. This nurse excused [themself] from room as resident continued to get more et more verbally abusive towards this nurse. CNA asked to sit with resident 1:1 for safety at this time. Nurse leader notified via text at this time. Will continue to monitor for increased aggression.A Nurse Progress Note, dated 09/23/21, read in part, N.O. [new order] discontinue Celexa [an antidepressant] and start Seroquel [an antipsychotic] 25mg qhs [every bed time] Dx. [diagnosis] Delusions.A Quarterly Minimum Data Set, dated [DATE], showed Resident #9 admitted to the facility on [DATE] with diagnoses to include psychotic disorder, anxiety, depression, pseudobulbar effect, and non-Alzheimer's dementia.A review of Resident #9's June 2025 MAR showed Resident #9 was prescribed Seroquel for delusional disorders.On 07/01/25 at 11:25 a.m., the DON was asked what diagnoses were on Resident #9's PASARR. They stated, Dementia and stroke diagnoses. They were asked if the delusional disorder diagnosis was included on the PASARR level 1. They stated, Delusion is a new symptom of dementia, so no it's not on there. The DON was asked if question #2 on the PASARR level 1 was answered correctly. They stated, I feel the delusional disorder was related to dementia, so I did not complete a new PASARR. The DON was asked if a resident was identified as having a newly evident or possible mental diagnosis, such as delusional disorder, after they have been admitted , what was the facility's process for referring the resident to the appropriate state-designated authority. They stated, If doctors put a new diagnosis in, I don't complete a new PASARR.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure accurate documentation of a diagnosis on a PASARR form for a mental health illness for 1 (#73) of 2 sampled residents reviewed for the need of a level II screening. The administrator identified 81 residents resided at the facility. Findings: An undated policy titled Policy for completion of PASRR's, read in part, Evaluate residents/patient prior to admission to facility. Attempt to get good history and physical, including mental health history as well as any intellectual disabilities.Contact OHCA (LOCEU) if person coming to your facility with known intellectual disabilities or evidence or diagnosis of severe mental illness. A review of Resident #73's PASARR, dated 06/06/25, showed question #2 marked No for diagnosis of a serious mental illness for schizophrenic, paranoid, panic, mood or other severe anxiety or depressive disorder, somatoform disorder, personality disorder, or other psychotic disorder, or other mental disorder that may lead to a chronic disability. A review of the diagnosis list per electronic medical record showed delusional disorder as an admitting diagnosis on 06/03/25. A care plan, dated 06/17/25, showed Resident #73 had diagnosis of delusional disorder. Resident #73's level one PASARR was not completed to include the delusional disorder diagnosis and the State office was not notified of the PASARR. On 07/01/25 at 10:33 a.m., the administrator provided the PASARR level 1. They stated delusional was the only mental health diagnosis they could see for a PASARR. They stated delusional disorder was a mental health disorder. On 07/01/25 at 11:15 a.m., the DON stated Resident #73's mental health diagnosis was metabolic, but felt like it was not. They stated the resident was never diagnosed with any schizophrenia or anything like that. The DON stated the diagnosis on the level 1 was marked correctly because it was caused by a known medical condition. The DON stated delusional disorder was a diagnosis for Resident #73 and it was a psychotic disorder. They stated they thought it was accurately coded at the time and stated the State office was not called about the PASARR.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours seven days per week.The administrator identified 81 residents resided in the facility.Findings:A PBJ [Payroll Based Journal] Staffing Data Report, dated 01/01/25 through 03/31/25, showed no RN hours on 03/30/25. A Timecard Report, dated 03/30/25, did not show RN coverage for eight consecutive hours.A Timecard Report, dated 06/01/25 through 06/30/25, did not show RN coverage for eight consecutive hours on 06/07/25.On 07/03/25 at 9:49 a.m., the administrator stated they had an RN scheduled for the dates above, but they called in. The administrator stated they replaced the RN with a license practical nurse.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure all components of the daily staffing information was posted and was readily accessible to residents and visitors for 1 of 1 observation. The administrator identified 81 residents resided in the facility. Findings: On 07/02/25 at 10:30 a.m., a staff roster with unit name, staff names, a date of 07/02/25, and shift schedule was on a clip board at the nurse's station on the skilled unit. There was no posted staffing with all required components on the skilled unit. On 07/02/25 at 10:49 a.m., there was a white board with the name [NAME] and [NAME] (halls) and it showed names of staff, and a date of 07/02/25. The whiteboard did not have all the required components of the posted staffing. On 07/02/25 at 10:54 a.m., the [NAME] hall had a whiteboard with staff names and titles. The whiteboard did not have all the required components of the posted staffing. On 07/02/25 at 11:16 a.m., the administrator and assistant administrator observed [NAME] hall, [NAME] and [NAME], and the skilled unit for posted staffing. On 07/02/25 at 10:29 a.m., LPN #4 stated they did not have any posted staffing on the skilled unit. They stated the staff roster was on a clip board at the nurse's station. On 07/02/25 at 10:46 a.m., CMA #2 stated what was posted on the whiteboard on [NAME] and [NAME] was to show who was working on those halls on that shift. On 07/02/25 at 11:34 a.m., the administrator stated the posted staffing did not meet the regulatory requirements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. EBP was followed during wound care observation for 1 (#13) of 2 sampled residents reviewed for pressure ulcers; b. dryer lint compartments were clean and free of excess lint for potential prevention of thorough drying and fire hazard observed during infection control observation of laundry room; andc. contact isolation procedure was followed during the provision of incontinent care for 1 (#32) of 3 sampled residents reviewed for incontinent care.The administrator identified 81 residents resided in the facility.Findings:1. On 07/01/25 at 10:44 a.m., the wound care nurse entered Resident #13's room to perform sacrum wound care treatment. They donned gloves. CNA #1 was in the resident's room. They had on gloves. On 07/01/25 at 10:55 a.m., the wound care nurse completed Resident #13's sacrum wound care and skin treatment with the assistance of CNA #1. The wound care nurse and CNA #1 did not have on gowns during the wound care and skin treatment.An undated facility policy titled ENHANCED BARRIER PRECAUTIONS (EBP), read in part, EBP are indicated for residents with any of the following: wounds .For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Wound care.A physician's order, dated 06/18/25, showed clean sacrum wound with normal saline and pat dry to mechanically debride wound to remove nonviable tissue. Apply Hydrafera Blue (foam dressing) over lightly packed iodoform (disinfectant) and collagen Ag (dressing), cover with 4x4 gauze, secure with border dressing. change daily and PRN. Apply nystatin crusting (skin-prep and nystatin powder) to wound edges with each dressing change. Apply triple paste (treats infections) and Calmoseptine (topical ointment) over nystatin crusting to periwound every day shift related to pressure ulcer of sacral region, stage 4.On 07/01/25 at 11:02 a.m., the wound care nurse stated they did not know what EBP was. They stated the precautions they took during routine wound care was the use of gloves, handwashing, and alcohol based hand rub. They stated they donned gowns if the resident was on contact precautions. On 07/01/25 at 11:38 a.m., the DON stated they were not sure what EBP was and the facility policy for EBP. 2. On 07/02/25 at 11:02 a.m., the laundry supervisor stated the lint traps for the three dryers were cleaned twice a day or as needed. There were two shifts. Observations made of the three dryers lint compartments with the laundry supervisor. They stated cleaning As needed was what was seen at the observation. All three compartment trays were full of lint and the first dryer had two balls of lint on the floor of the compartment where some had fallen off of the tray. On 07/02/25 at 11:05 a.m., laundry aide #1 observed the compartments and stated there was more than average on them and needed to be cleaned. 3. On 06/30/25 at 11:17 a.m., Resident #32 had PPE carts outside of their room and a sign posted next to their door which read, Contact Isolation.On 06/20/25 at 11:25 a.m., CNA #2 was observed inside of Resident #32's room wearing only gloves. On 07/02/25 at 1:34 p.m., CNAs #2 and #3 donned gowns and gloves and entered Resident #32's room for incontinent care. CNA #3 lowered Resident #32's head of bed and then unfastened Resident #32's brief. CNA #3 wiped the resident's peri area front to back three times with three different wipes. Both CNAs assisted to roll Resident #32 to their left side. CNA #3 wiped Resident #32's buttocks from front to back three times with three different wipes. CNA #3 removed the resident's urine soiled brief and threw it in the trash can. CNA #3 placed a new, clean brief under Resident #32 and both CNAs assisted to roll the resident to their back, then to their right side. CNA #3 pulled the remainder of the clean brief under the resident and then assisted the resident to roll onto their back. CNA #2 pulled the clean brief up between Resident #32's legs, fastened the brief and began removing trash. CNA #3 did not change gloves throughout the procedure. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/02/25 at 1:42 p.m., CNA #3 was observed to have the same pair of gloves on that they used for Resident #32's incontinent care. CNA #3 lifted Resident #32's head and adjusted their pillow then covered the resident with a blanket. CNA #3 moved the resident's bedside table closer to Resident #32 and touched the top of the resident's diet coke bottle to move it closer to the resident.On 06/20/25 at 11:28 a.m., CNA #2 was asked what PPE was supposed to be worn inside a contact isolation room. They stated, Gown and gloves. CNA #2 was asked if they had on a gown inside of Resident #32's room. They stated, No.On 06/30/25 at 12:05 p.m., LPN #1 was asked what PPE was required to be worn inside of a contact isolation room. They stated, Gloves and gown. On 07/02/25 at 1:45 p.m., CNA #3 doffed their PPE and was asked if they missed any opportunities for glove changes. They stated, When I put the new brief on. CNA #3 was asked if they had the same gloves on throughout entire procedure and they stated, Yes. CNA #3 was asked what all did they touch with their gloves on after providing incontinent care. They stated, Blankets, the resident's head, pillow, and bedside table. CNA #3 was asked if they touched the top of Resident #32's bottle of diet coke. They stated, Yes, and the bed control crank.An MDS, dated [DATE], showed Resident #32 was admitted on [DATE] with diagnoses to include non-traumatic brain dysfunction and Alzheimer's disease.