

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/25/2026
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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure their ice machine was maintained in a sanitary condition. The DON identified 99 residents received food and drinks from the kitchen. Findings: On 06/21/26 at 10:53 a.m., the ice machine located in the dining room was observed to have a black substance inside the ice storage bin when wiped with a paper towel. The facility had no documentation to show the ice machine was cleaned and sanitized. An Ice Machines and Ice Storage Chests policy, dated 01/01/12, read in part, To help prevent contamination of ice machines, staff shall clean and sanitize the tray and ice scoop daily. On 06/21/26 at 10:54 a.m., dietary #1 stated the ice machine was cleaned by environmental staff. Dietary #1 stated the ice machine was dirty after they witnessed the paper towel used to wipe the inside of the ice machine had a black substance on it. On 06/21/26 at 11:30 p.m., the certified dietary manager stated dietary cleaned the ice machine weekly, and maintenance cleaned it quarterly. On 06/24/26 at 10:45 a.m., the certified dietary manager stated dietary staff had only been wiping down the outside of the ice machine. The certified dietary manager stated they thought maintenance had been cleaning the ice machine, but there was no log.		

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to ensure the required PBJ staffing data was submitted to CMS within the mandated timeframe. The DON identified 99 residents resided in the facility. Findings: A PBJ Staffing Data Report, dated 01/01/26 through 03/31/26 (Fiscal Year quarter 2 2026), showed the facility had not provided the staffing data to CMS for the PBJ staffing data report for quarter two of federal fiscal year 2026. On 06/24/26 at 2:59 p.m., the administrator stated they could not locate documentation the PBJ staffing data was submitted to CMS for quarter two.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to implement their legionella water management program to prevent waterborne contaminants. The DON identified 99 residents resided in the facility. Findings: A Legionella Water Management Program policy, dated 09/01/22, read in part, The water management program includes the following elements: a. A detailed description and diagram of the water system in the facility. b. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. c. The identification of situations that can lead to Legionella growth. d. Specific measures used to control the introduction and/or spread of Legionella. e. A diagram of where control measures are applied. f. A system to monitor control limits and the effectiveness of control measures. g. Documentation of the program. The facility had no documentation to show measures were taken to prevent legionella. On 06/25/26 at 3:21 p.m., the administrator stated the facility did not have a water management program in place. The administrator stated maintenance was only checking water temperatures weekly to prevent burns. The administrator stated there was no diagram of the facility's water system, no testing of the water, and no flushing of the pipes being conducted by anyone in the facility.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure the interdisciplinary team determined a resident could safely self-administer oral medications for 2 (#22 and #75) of 2 sampled residents reviewed for self-medication administration. The DON identified 99 residents resided in the facility. Findings: 1. On 06/22/26 at 10:05 a.m., 15 medications of different colors were observed in a medication cup in Resident #75's room. There was no staff in the room. An admission assessment for Resident #75, dated 05/21/26, showed the resident had a BIMS score of 3, which indicated the resident was severely impaired in cognition for daily decision making. On 06/22/26 at 10:02 a.m., Resident #75 stated staff did not observe them take their medications. They stated staff usually set the medications in their room and leave. On 06/22/26 at 10:17 a.m., CMA #1 stated the medications in the cup were Resident #75's morning medications. CMA #1 stated the medications included an opioid pain medication. On 06/22/26 at 10:19 a.m., CMA #1 stated they did not observe the resident take their medication. They stated they were supposed to observe the resident take their medication. On 06/22/26 at 10:21 a.m., CMA #1 stated Resident #75 did not have an order for self-administration of medication. On 06/25/26 at 8:23 a.m., the DON stated residents could self-administer medications if the provider and the interdisciplinary team determined safe administration. On 06/25/26 at 8:27 a.m., the DON stated staff should observe residents take their medications. They stated Resident #75 did not have a self-administration of medication assessment and a physician order to self-administer medications. 2. On 06/23/26 at 8:17 a.m., Resident #22 was observed to take two pills. There was a cup with medication pills in them. Resident #22 was seated in the center of the dining room with their back towards CMA #2. CMA #2 was at the medication cart across the dining room with their back turned to Resident #22. A policy titled Administering Medications, revised 04/2019, read in part, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. An admission assessment for Resident #22, dated 04/14/26, showed the resident had a BIMS score of 13, which indicated the resident's cognition was intact for daily decision making. On 06/23/26 at 8:18 a.m., Resident #22 stated there were 11 medication pills left in the cup. They stated they took two pills. Resident #22 stated CMA #2 gave them their morning medications. On 06/23/26 at 8:41 a.m., CMA #2 stated they gave Resident #22 their morning medications. CMA #2 stated the medications included an opioid pain medication. On 06/23/26 at 8:42 a.m., CMA #2 stated they did not observe Resident #22 take their medications. They stated the resident should be observed to take their medication. On 06/25/26 at 8:30 a.m., the DON stated Resident #22 did not have a self-administration of medication assessment and a physician order to self-administer medications.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to inform a resident's representative on the risks of psychotropic medications for 1 (#34) of 5 sampled residents whose clinical records were reviewed for unnecessary medications. The DON identified 67 residents on psychotropic medications. Findings: A facility policy titled Psychotropic Medication Use, dated 2001, read in part, Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings). A review of Resident #34's medication orders showed the resident had active orders for Risperdal oral tablet 1 MG, an antipsychotic medication, and risperidone (generic name of Risperdal) oral tablet 0.25 MG. The medication orders showed Resident #34 had initially received the order for risperidone oral tablet in 2025. There was no documentation to show Resident #34, or their family member were informed of the risk for taking the antipsychotic medication. A quarterly MDS assessment for Resident #34, dated 05/13/26, showed the resident had a BIMS score of 1, which indicated severe cognitive impairment. A MAR, dated 06/2026, showed Resident #34 had been given Risperdal as ordered. On 06/24/26 at 10:52 a.m., Resident #34's POA stated the facility contacted them to talk about the resident's medications but did not inform them of the risks associated with the antipsychotic medication that was being given. Resident #34's POA stated they were not asked to sign any antipsychotic consent forms on Resident #34's behalf. On 06/25/26 at 8:27 a.m., LPN #1 stated the risks and benefits of a new medication were discussed with a resident's family before it was administered. On 06/25/26 at 9:05 a.m., the facility provided a blank antipsychotic consent form for Resident #34. The consent form listed the risks and benefits associated with antipsychotics and did not contain the name of any antipsychotic medications. On 06/25/26 at 9:50 a.m., the DON stated they could not locate the antipsychotic consent form for Resident #34 for the initial order date for risperidone.		

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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.		

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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. Based on observation, record review, and interview, the facility failed to evaluate a resident for the need of a PASSAR level II referral when they received a new diagnosis of mental illness for 1 (#65) of 1 sampled resident reviewed for PASSAR screening. The DON identified 99 residents resided in the facility. Findings: On 06/24/26 at 11:54 a.m., Resident #65 was observed in the dining room for lunch and refused to eat when offered food by a staff member. A PASSAR level I screening for Resident #65, dated 11/12/12, showed the resident had no qualifying diagnosis or mental illness to require a referral for a level II screen. A physician's order for Resident #65, dated 10/20/20, read in part, Paxil [antidepressant] 30 mg give one tablet by mouth one time a day related to recurrent depressive disorder. A Behavioral Assessment, Intervention, and Monitoring policy, dated 02/01/25, read in part, New onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder are referred for a PASSAR level II evaluation. An admission record for Resident #65, dated 06/25/26, showed the resident was diagnosed with recurrent mental disorder 10/20/16, violent behavior on 10/17/17, psychotic disorder with delusion due to a known physiological condition on 02/23/18, and unspecified dementia on 10/01/22. On 06/25/26 at 8:13 a.m., MDS Coordinator #1 stated when Resident #65 was diagnosed with psychotic disorder with delusions, violent behavior, and recurrent depressive disorder, a referral for a PASSAR level II screen should have been completed. MDS Coordinator #1 stated they were not aware why the resident had not been rescreened since the dementia diagnosis was not received until after the mental illness diagnoses.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 (#23) of 24 sampled residents reviewed for baseline care plans. The DON identified 99 residents resided in the facility. Findings: A review of Resident #23's electronic health record showed the resident had diagnoses which included delusional disorders, unspecified dementia, unspecified psychosis, hyperlipidemia, and generalized anxiety disorder. A review of Resident #23's electronic health record face sheet showed the resident was admitted to the facility on [DATE]. The facility had no documentation to show a baseline care plan was completed within 48 hours after admission. An admission MDS assessment for Resident #23, dated 05/14/26, showed the resident had a BIMS score of 1, which indicated severe cognitive impairment. On 06/25/26 at 2:40 p.m., the ADON stated the baseline care plan for Resident #23 had not been completed because it could not be found in their electronic health record.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to implement comprehensive care plan interventions regarding falls for 1 (#84) of 24 sampled residents reviewed for care plans. The DON identified 99 residents resided in the facility. Findings: On 06/21/26 at 11:24 a.m, Resident #84 was observed in the dining room with purplish dark bruises on their cheeks, forehead, and around their neck. A knot was observed on the resident's left temporal region above the ear. Resident #84 was observed wearing fuzzy non-grip blue socks. On 06/23/26 at 2:46 p.m., Resident #84 was observed sitting in the memory care common room with fuzzy non-grip blue socks on. On 06/24/26 at 3:12 p.m., Resident #84 was observed sleeping alone in their room recliner. No floor grip tape or call light tape was observed. On 06/25/26 at 2:50 p.m., no sign hung on the wall by the bed, no call light tape, and no grip tape on the floor was observed in Resident #84's room. A facility policy titled Falls - Clinical Protocol, dated 2001, read in part, If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed. A quarterly MDS assessment for Resident #84, dated 05/11/26, showed a BIMS score of 1, which indicated severe cognitive impairment. A care plan for Resident #84, dated 05/12/26, showed the resident had a fall on 04/02/26, 04/08/26, 05/07/26, and 06/08/26. The care plan showed interventions for fall prevention which included stop no fall sign placed on wall close to bed, yellow tape on the call light, grip tape on the floor, maintain bed in low position, and encourage proper footwear. A Morse Fall Scale assessment for Resident #84, dated 06/08/26, showed a score of 55, which indicated a high risk for falling. On 06/25/26 at 2:27 p.m., the ADON stated Resident #84's fall interventions included to assist with transfers, frequent checks, bright colored tape on call light, and a call don't fall sign by their bed. The ADON stated Resident #84 had shoes they wore that helped prevent falls. The ADON stated Resident #84 had a therapy note, dated 06/10/26, in their electronic health record which suggested interventions post fall that were not added to the current care plan. The ADON stated they were not sure who therapy communicated those interventions with. The ADON stated MDS coordinators made changes to care plans and could see the progress notes. On 06/25/26 at 3:08 p.m., CNA #1 stated there was no sign by Resident #84's bed, no tape on the call light, and the bed was not lowered to the lowest position.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to assess and provide care for a resident with edema for 1 (#23) of 24 sampled residents reviewed for quality of care. The DON identified 99 residents resided in the facility. Findings: On 06/21/26 at 3:40 p.m., Resident #23 was observed sitting in the memory care common room with no socks on. Resident #23's feet were observed swollen. On 06/23/26 at 2:39 p.m., Resident #23 was observed sitting on a recliner with yellow socks on in the memory care common room. Resident #23's feet were observed slightly swollen. The full condition of their feet could not be determined due to the resident was wearing socks. A review of Resident #23's electronic health record did not show a baseline care plan had been completed. The record did not show Resident #23 had been completely assessed to determine potential existing health conditions on admission. A nursing admission screening/history for Resident #23, dated 05/01/26, showed the assessment did not have any documentation in the extremities/gait/mobility section. A nursing note for Resident #23, dated 05/07/26, showed edema was noted to upper and lower extremities. An admission MDS assessment for Resident #23, dated 05/14/26, showed the resident had a BIMS score of 1, which indicated severe cognitive impairment. A nursing note for Resident #23, dated 06/25/26 at 2:32 p.m., read in part, per exight [sic] foot 1+ am pedal edema to both feet. R foot 1+ left foot trace. On 06/25/26 at 12:08 p.m., CNA #5 stated they had noticed Resident #23's feet were purple but did not know much about them. CNA #5 stated they did not check Resident #23's feet or notice if the resident was wearing their socks that day. On 06/25/26 at 12:38 p.m., RN #1 stated they did not think Resident #23 had edema in their feet. They stated the condition of Resident #23's feet might have been something they were born with. On 06/25/26 at 2:47 p.m., RN #1 stated Resident #23's feet did have some swelling, and the measurements were 1+ edema on the right left and trace edema on the left leg. RN #1 stated they had not assessed the pedal areas of the feet. RN #1 stated a nursing aide would be the one to check the resident's feet. They stated Resident #23 was combative and they did not like checking their feet. On 06/25/26 at 4:00 p.m., the medical director stated they had seen Resident #23 plenty of times. They stated Resident #23 probably had edema, but everyone at the facility had swollen feet. The medical director stated they would have to check the Resident #23's healthcare notes to make sure. On 06/25/26 at 4:16 p.m., the DON stated if a resident had edema in their legs, then the legs would need to be elevated. The DON stated the provider would need to be notified, and the resident might need Lasix (diuretic medication). They stated staff should have been checking the resident for edema every shift even if the resident was on hospice. The DON stated they would have to look at the facility's policies for assessments to see what the staff needed to document in regard to edema. They stated the staff should have been documenting their findings.		

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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.		