STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375527	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Road Nursing & Rehab Center	1404 North Garland Road Enid, OK 73703

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a resident had a physician's order and a self-administration of medication assessment for 1 (#6) of 3 sampled residents reviewed for medication administration.The administrator identified 97 residents resided in the facility. Findings: On 08/20/25 at 12:49 p.m., fluticasone propionate (a corticosteroid) nasal spray was observed on Resident #6's bedside table.A MEDICATION PROGRAM policy, revised 12/01/23, read in part, Residents who self-administration their medication and keep them locked in their room must be counseled at least monthly by community staff to ascertain if the residents continue to be capable of self-administering their medications/treatments and if security of the medications can continue to be maintained. The community must keep a written record of such counseling.A physician's order, dated 03/11/25, showed fluticasone propionate nasal spray 50 micrograms, give one spray twice a day for unspecified cough.Resident #6's quarterly resident assessment, dated 08/09/25, showed the resident had diagnoses which included congestive heart failure and chronic obstructive pulmonary disease. The assessment showed the resident's cognition was intact with a BIMS score of 14.On 08/20/25 at 12:50 p.m., Resident #6 stated they took the nasal spray once a day.On 08/20/25 at 1:48 p.m., LPN #3 stated the resident had to have a physician's order to self-administer medications.On 08/20/25 at 1:54 p.m., LPN #3 stated the resident had fluticasone propionate nasal spray on bedside table. They stated the nasal spray should be administered twice a day. LPN #3 stated they could not locate a resident self-administration assessment for the nasal spray.On 08/20/25 at 1:57 p.m., LPN #3 stated they could not locate an order for self-administration of the nasal spray. On 08/20/25 at 1:58 p.m., LPN #3 stated they initially educated Resident #6 on the administration of the nasal spray, but no other education was provided since then.On 08/20/25 at 2:00 p.m., the DON stated residents would need an order and a self-administration assessment to self-administer medications.On 08/20/25 at 2:04 p.m., the DON stated they could not locate an order and an assessment for self-administration of the nasal spray.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician when a resident:a. missed their prescribed antibiotic dose; and b. had an abnormal heart rate for 1 (#6) of 3 sampled residents reviewed for medication administration.The administrator identified 97 residents resided in the facility.Findings:A MEDICATION-GUIDELINES ON CLINICAL PRACTICE policy, revised 01/12/20, read in part, Staff will provide medications in accordance with standard practice guidelines.Resident #6's quarterly resident assessment, dated 08/09/25, showed the resident had diagnoses which included congestive heart failure and unspecified atrial fibrillation.A physician's order, dated 07/24/25, showed metoprolol succinate (an antihypertensive) 50 mg tablet, extended release for essential primary hypertension. Give one tablet by mouth three times a day. Take one 50mg tablet if systolic blood pressure is less than 110.A physician's order, dated 08/03/25, read in part, ciprofloxacin hydrochloride (an antibiotic) 500 mg tablet for urinary tract infection. Start 08/04/25 at 08:00 [8:00 a.m.]. Give 500 mg by mouth twice a day at 8:00 a.m. and 8:00 p.m. Stop on 08/11/25 at 8:00. Finish all of this medication unless otherwise directed.An August 2025 Medication Record for;a. ciprofloxacin hydrochloride showed Resident #6 had a missed dose on 08/04/25 for 8:00 a.m. and 8:00 p.m. dose, and on 08/11/25 for 8:00 a.m. dose; andb. metoprolol showed the resident had missed their metoprolol dose on 08/15/25 for the 12:00 p.m. and 8:00 p.m. doses. The record showed the resident received metoprolol on 08/16/25 at 8:00 a.m. with a heart rate of 120 bpm.On 08/22/25 at 11:39 a.m., LPN #2 stated they could not locate documentation the physician was notified of the missed antibiotic doses.On 08/22/25 at 11:53 a.m., LPN #2 stated they would notify the physician of the elevated heart rate and rechecked until the resident returned to their baseline heart rate.On 08/22/25 at 11:56 a.m., LPN #2 stated they could not locate documentation the physician was notified of the elevated heart rate.On 08/22/25 at 1:10 p.m., the DON stated the metoprolol parameters meant to take one 50 mg tablet if systolic blood pressure is less than 110.On 08/22/25 at 1:29 p.m., the DON stated notification to the physician on elevated heart rate depended on the physician's preference. They stated the facility's physician informed facility staff verbally of their notification preference. The DON stated the facility's physician wanted to be notified of residents' heart rate above 150 bpm for non-frequent episodes or 130 bpm if regularly elevated.On 08/22/25 at 1:39 p.m., the DON stated the physician should be notified of the missed antibiotic doses.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to provide showers as scheduled for 3 (#2, 5, and #6) of 3 sampled residents reviewed for showers.The DON identified 97 residents required assistance with bathing. Findings:A BATHING (NOT PARTIAL OR COMPLETE BED BATH) policy, revised 02/12/20, read in part, Staff will provide bathing services for residents within standard practice guidelines.1. Resident #2's quarterly resident assessment, dated 07/31/25, showed the resident had diagnoses which included unspecified hemiplegia affecting left nondominant side. The assessment showed the resident's cognition was intact with a BIMS of 15. The assessment showed the resident required setup or clean-up assistance with showers.There was no documentation the resident had a shower on 06/03/25, 06/05/25, 06/07/25, 06/24/25, and 06/26/25.The June 2025 shower sheets showed the resident refused a shower on 06/12/25, 06/14/25, 06/19/25, and 06/25/25.Resident #2 had three out of 12 showers for the month of June 2025.There was no documentation the resident had a shower on 07/01/25, 07/03/25, 07/08/25, 07/15/25, 07/19/25, 07/22/25, 07/24/25, 07/26/25, 07/29/25, and 07/31/25.The July 2025 shower sheets showed the resident refused a shower on 07/10/25 and 07/17/25.Resident #2 had two out of 14 showers for the month of July 2025.There was no documentation the resident had a shower on 08/02/25, 08/05/25, 08/14/25, and 08/16/25.Resident #2 had four out of eight showers from 08/01/25 through 08/19/25.On 08/20/25 at 11:22 a.m., Resident #2 stated their shower schedule was on Tuesday, Thursday, and Saturday. They stated they went five days without a shower about three weeks ago. They stated they took showers at night, and staff would say they refused showers because they did not want to give them showers at night.On 08/21/25 at 3:02 p.m., CNA #1 stated they provided residents showers as scheduled. They stated showers were scheduled per beds in resident rooms.On 08/21/25 at 3:02 p.m., CNA #1 stated if a resident refused a shower, they would make multiple attempts and notify the nurse. They stated they would document refusal on the shower sheets. They stated they had residents signed off on the refusal documentation a couple of times, but did not see any sign off on the shower sheets provided to the surveyor.On 08/21/25 at 3:07 p.m., CNA #1 stated Resident #2's shower schedule was on Tuesday, Thursday, and Saturday. They stated they did not see any showers for the dates above. 2. Resident #5's discharge assessment return not anticipated, dated 07/12/25, showed the resident had diagnoses which included personal history of transient ischemic attack and cerebral infarction without residual deficits. The assessment showed the resident required supervision or touching assistance with showers.There was no documentation the resident had a shower on 06/25/25 and 06/30/25.The June 2025 shower sheets showed the resident refused a shower on 06/20/25.Resident #5 had three out of five showers from 06/18/25 through 06/30/25.There was no documentation the resident had a shower on 07/04/25, 07/07/25, 07/09/25, 07/11/25.Resident #5 had one out of five showers from 07/01/25 through 07/11/25.On 08/21/25 at 3:32 p.m., CNA #1 stated they did not see any showers for the dates above. 3. Resident #6's quarterly resident assessment, dated 08/09/25, showed the resident had diagnoses which included chronic obstructive pulmonary disease and unspecified osteoarthritis. The assessment showed the resident's cognition was intact with a BIMS of 14. The assessment showed the resident required partial to moderate assistance with showers.There was no documentation the resident had a shower on 06/03/25, 06/05/25, 06/07/25, 06/10/25, 06/14/25, 06/19/25, 06/24/25, and 06/28/25.Resident #6 had four out of 12 showers for the month of June 2025.There was no documentation the resident had a shower on 07/01/25, 07/03/25, 07/05/25, 07/08/25, 07/12/25, 07/17/25, 07/22/25, 07/24/25, 07/26/25, and 07/31/25.The July 2025 shower sheets showed the resident refused a shower on 07/29/25.Resident #6 had three out of 14 showers for the month of July 2025.There was no documentation the resident had a shower on 08/05/25, 08/09/25, 08/12/25, and 08/14/25.Resident #6 had four out of eight showers from 08/01/25 through 08/19/25.On 08/20/25 at 12:41 p.m., Resident #6 stated they went 10 days without a shower. They stated they never refused a shower.On 08/20/25 at 12:42 p.m., Resident #6's representative stated staff would write refuse on the paper but that was false.On 08/21/25 at 3:27 p.m., CNA #1 stated Resident #6's shower schedule was on Tuesday, Thursday, and Saturday. They stated they did not see any showers for the dates above.On 08/21/25 at 3:34 p.m., LPN #1 stated the CNAs would inform the nurse of resident refusal of showers and the nurse would encourage the resident to have a shower. They stated the CNA would document refusal on the shower sheet. LPN #1 stated the facility was going to implement resident sign off on refusals, but they had not implemented the process at this time.On 08/21/25 at 3:41 p.m., the DON stated they expected staff to follow resident shower schedules to provide showers.

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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 record review and interview, the facility failed to ensure a resident with low blood sugar received appropriate care for 1 (#5) of 3 sampled residents reviewed for medication administration.The DON identified 28 residents received insulin resided in the facility. Findings:A HYPOGLYCEMIA TREATMENT policy, revised 02/12/20, read in part, Guidelines for Mild Hypoglycemia: Treat, even if biochemical hypoglycemia is not present with a. glucose-15 40% oral gel (Dextrose) gm gel, b. Glucose 15 gm tablets.Repeat blood glucose level in fifteen (15) minutes.A physician's order, dated 06/21/25, showed Humalog kwikpen 200 units/1mL solution. Give one dose subcutaneous for blood sugar 70-100= 0 units, 100-150= 4 units, 151-200= 6 units, 201-250= 8 units, 251-300= 10 units, 301-350= 12 units, 351-400= 14 units, 401-500= 16units, over 500, give 5 additional fast acting units before meals and bedtime for type 2 diabetes mellitus with ketoacidosis without coma.A Medication Record for Humalog sliding scale on 07/06/25 for 7:00 a.m. dose, showed insulin was held due to vital signs parameters. The record showed the resident's blood sugar was 39.There was no documentation Resident #5's blood sugar was rechecked in 15 minutes according to the facility's hypoglycemia policy.There was no documentation interventions were implemented for the resident's low blood sugar according to the facility's hypoglycemia policy.Resident #5's discharge assessment return not anticipated, dated 07/12/25, showed the resident had diagnoses which included type 2 diabetes mellitus without complications.On 08/21/25 at 3:59 p.m., the ADON stated they could not see what interventions were done for Resident #5's low blood sugar on 07/06/25.On 08/21/25 at 4:05 p.m., the ADON stated they could not locate documentation to show a recheck was performed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to administer medication as ordered for 2 (#5 and #6) of 3 sampled residents reviewed for medication administration.The administrator identified 97 residents resided in the facility. Findings:A MEDICATION-GUIDELINES ON CLINICAL PRACTICE policy, revised 01/12/20, read in part, Staff will provide medications in accordance with standard practice guidelines.1. A physician's order for Resident #5, dated 06/18/25, showed insulin glargine 100units/1mL, give 30 units subcutaneous at bedtime for type 2 diabetes mellitus without complications.A June 2025 Medication Record showed M on 06/20/25 for 9:00 p.m. dose. Resident #5's discharge assessment return not anticipated, dated 07/12/25, showed the resident had diagnoses which included type 2 diabetes mellitus without complications. On 08/22/25 at 11:32 a.m., LPN #2 stated they were not sure what the M meant on the medication record. They stated the medication record did not show the insulin was administered on 06/20/25.On 08/22/25 at 11:33 a.m., LPN #2 stated if a resident refused their blood sugar checks or medications, they would mark it as refused, notify the physician, and document in the nurses' notes. 2. A physician's order for Resident #6, dated 03/18/25, showed magnesium oxide (an electrolyte supplement) 400 mg. Give one tablet by mouth one time daily for constipation.A physician's order for Resident #6, dated 07/24/25, showed metoprolol succinate (an antihypertensive) 50 mg tablet, extended release for essential primary hypertension. Give one tablet by mouth three times a day. Take one 50mg tablet if systolic blood pressure is less than 110.A physician's order, dated 08/03/25, read in part, ciprofloxacin hydrochloride (an antibiotic) 500 mg tablet for urinary tract infection. Start 08/04/25 at 08:00. Give 500 mg by mouth twice a day at 8:00 a.m. and 8:00 p.m. Stop on 08/11/25 at 8:00. Finish all of this medication unless otherwise directed.Resident #6's quarterly resident assessment, dated 08/09/25, showed the resident had diagnoses which included congestive heart failure and unspecified atrial fibrillation. The assessment showed the resident's cognition was intact with a BIMS of 14.There was no documentation magnesium was administered twice a day from 08/01/25 through 08/21/25.An August 2025 Medication Record for ciprofloxacin hydrochloride showed;a. H on 08/04/25 for 8:00 a.m. dose,b. M on 08/04/25 for 8:00 p.m. dose, andc. M on 08/11/25 for 8:00 a.m. dose.An August 2025 Medication Record for metoprolol showed;a. M on 08/15/25 for 12:00 p.m. dose,b. H on 08/15/25 for 8:00 p. m. dose with BP of 106/67 mmHg and HR of 116 bmp, and c. H on 08/18/25 for 8:00 p.m. dose with BP of 102/60 mmHg and HR of 109 bmp.On 08/20/25 at 12:50 p.m., Resident #6 stated they sometimes had a problem getting their medications from the nurses even if they asked. They stated they missed some of their medications.On 08/22/25 at 10:38 a.m., CMA #1 stated they were to administer antibiotics as ordered. They stated the H on the resident's August 2025 medication record could mean held. They stated the antibiotic could have been held because the medication was not in the facility.On 08/22/25 at 10:46 a.m., CMA #1 stated the reason documented for holding the antibiotic was due to vital signs parameters.On 08/22/25 at 10:56 a.m., CMA #1 stated they notified the nurse because that was their process, but could not remember who the nurse on duty was on 08/04/25.On 08/22/25 at 10:57 a.m., CMA #1 stated they were not sure what M meant on the resident's August 2025 medication record for the medications above.On 08/22/25 at 11:02 a. m., CMA #1 stated the parameter on the metoprolol could mean only give if the systolic blood pressure was less than 110.On 08/22/25 at 11:04 a.m., CMA #1 stated they were not sure the reason for holding the metoprolol on 08/15/25 and 08/18/25.On 08/22/25 at 11:05 a.m., CMA #1 stated the medication record did not show the medications above were administered.On 08/22/25 at 11:38 a.m., LPN #2 stated the process for holding medications was per physician orders and if the resident refused.On 08/22/25 at 11:45 a.m., LPN #2 stated the resident did not receive the antibiotic as ordered.On 08/22/25 at 11:50 a.m., LPN #2 stated they would had clarified the metoprolol parameters order prior to administering or holding it due to the exclamation mark in the order. They stated they did not know what M meant on the resident's medication record.On 08/22/25 at 11:52 a.m., LPN #2 stated the metoprolol was not administered as ordered for the dates above.On 08/22/25 at 12:56 p.m., CMA #1 stated they did not remember administering any magnesium for Resident #6. They stated the medication did not show up for staff to administer it.On 08/22/25 at 1:08 p.m., the DON stated the medication record did not show Resident #6 received their magnesium oxide from 08/01/25 through 08/21/25.On 08/22/25 at 1:10 p.m., the DON stated the metoprolol parameters meant to take one 50 mg tablet if systolic blood pressure is less than 110.On 08/22/25 at 1:18 p. m., the DON stated according to the metoprolol order, it should not have been held on 08/15/25 at 8:00 p.m. dose. They stated the medication record showed the medication was held on 08/18/25 and they could not

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure the amount of insulin administered was documented on a resident who received sliding scale insulin for 1 (#5) of 3 sampled residents reviewed for medication administration.The DON identified 28 residents received insulin resided in the facility. Findings:A MEDICATION-GUIDELINES ON CLINICAL PRACTICE policy, revised 01/12/20, read in part, Staff will provide medications in accordance with standard practice guidelines.A physician's order for Resident #5, dated 06/21/25, showed Humalog kwikpen 200 units/1mL solution. Give one dose subcutaneous for blood sugar 70-100= 0 units, 100-150= 4 units, 151-200= 6 units, 201-250= 8 units, 251-300= 10 units, 301-350= 12 units, 351-400= 14 units, 401-500= 16units, over 500, give 5 additional fast acting units before meals and bedtime for type 2 diabetes mellitus with ketoacidosis without coma.A Medication Record reviewed from 06/21/25 through 06/30/25 did not show how many units of the sliding scale insulin was administered for all blood sugars above 100.A physician's order for Resident #5, dated 07/06/25, showed Humalog kwikpen 200 units/1mL solution. Give one dose subcutaneous for blood sugar 70-100= 0 units, 100-150= 2 units, 151-200= 4 units, 201-250= 6 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, 401-500= 14units, over 500, give 5 additional fast acting units before meals and bedtime for type 2 diabetes mellitus with ketoacidosis without coma.A Medication Record reviewed from 07/01/25 through 07/12/25 did not show how many units of the sliding scale insulin was administered for all blood sugars above 100. Resident #5's discharge assessment return not anticipated, dated 07/12/25, showed the resident had diagnoses which included type 2 diabetes mellitus without complications.On 08/21/25 at 2:44 p.m., the DON stated staff followed the sliding scale order. They stated what they should give was in the order.The DON could not provide documentation on how much of the Humalog was administered for blood sugars above 100 on the dates reviewed.On 08/21/25 at 4:14 p.m., LPN #4 stated the electronic health system the facility used for medication administration may or may not given them an option to document the amount of insulin administered. They stated they personally put that information in a note. LPN #4 stated the facility should provide the option to input what was administered.On 08/21/25 at 4:25 p.m., LPN #4 stated it was important to know what was previously administered for insulin treatment, interventions, and emergencies.