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	11/21/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, and interview, the facility failed to ensure a resident's care plan was updated with interventions to prevent wandering into other residents' room for 1(#4) of 3 sampled residents reviewed for care plans interventions. The administrator identified 102 residents resided in the facility. Findings: On 09/23/25 at 3:30 p.m., Resident #5 was observed seated on their walker at the nurses' station with a fast-food bag in their hands. Resident #5's care plan, dated 6/20/25, showed Resident #5 had a focus for wandering into other residents' rooms. The interventions were dated 06/20/25 which included redirecting the resident and analyzing the circumstances, times, and places to deescalate the resident's behavior. Resident #5's nursing note, dated 07/08/25, read in part, .resident found in [gender withheld] residents' bed. Resident asleep near private area. Both residents fully clothed. Resident removed from [gender withheld] residents' bed and took back to [their] own room. Resident #5's nursing note, dated 07/10/25, read in part, . Resident found trying to enter a [gender withheld] resident room. Resident was redirected. [They] did not do well with the redirect. Resident tried to punch me in the face multiple times. [They] did finally go back to [their] room, and a close watch was kept to ensure [they] would not enter another resident's room.Resident #5's nursing note, dated 07/12/25, showed resident #5 was going into other residents' rooms and was redirected. The showed the resident became violent with staff and was hitting, kicking, and trying to bite the staff when they redirected them. Resident #5s nursing note, dated 08/03/25, showed the resident was in another resident bathroom. The note showed the resident hit a CNA on the left cheek when they were redirected from the resident's bathroom. Resident #5's re-admission assessment, dated 09/02/25, showed their cognition was significantly impaired and was unable to complete the BIMS assessment. The assessment showed the resident had wandering behaviors that occurred 4 to 6 days during the look back period. The assessment showed Resident #5 had diagnoses which included dementia, cardiac murmur, and hypertension.Resident #5s nursing note, dated 09/04/25, showed they were wondering into other residents' bathrooms. The note showed the resident was easily redirected. Resident #5's nursing note, dated 09/18/25, read in part, .Resident was briefly in another resident's room looking in [their] closet. The roommate was upset by this and called their daughter. The daughter insisted the police be called so that a report could be filed.A facility document titled Incident Case report, dated 09/21/25, read in part, .CNA [name withheld] reported to this RN that pt was out of bed during bed checks at 3:00 am. [They] tried to redirect [them] to bed in which [they] tried to hit [CNA]. Per [CNA] statement, [Resident #5] took thee swings and on the last swing [they] fell. The CNA was not harmed or hit. The RN went to assess the patient. [They] had gotten up on their own.There were no revisions made to Resident #5s care plan after each documented incident Resident #11 wandered into other residents' rooms. 2. On 09/23/25 at 2:51 p.m., Resident #4 was observed lying in bed. The resident was able to sit up on the side of the bed without assistance. The resident presents as alert and oriented time four. Resident #4's re-admission assessment, dated 07/10/25, showed their cognition was intact with a BIMS score of 14. The assessment showed the resident was admitted with diagnoses which included acute kidney failure, nontraumatic intracerebral hemorrhage, and type 2 diabetes.Resident #4's nurses notes, dated 09/18/25, read in part, .Late Entry for 09/1825 05:15 AM resident was upset to find another resident in her room going through [her] roommates' closet. 3. On 09/24/25 at 9:35 a.m., Resident #11 was observed lying in bed with head of bed elevated at twenty degrees. Their call light was in reach, the bed was low, and a fall mat was in place. The resident only smiles and did not respond to any questions. A facility document titled Incident Case report, dated 07/08/25, read in part, .Resident found in female residents' room [they] had fallen asleep with [their] on [other residents] bed. Both residents fully clothed. Resident removed from [gender withheld] residents' bed and took back to [their] own room. PCP, DON, and left voice mail on [family representatives] phone to call back.Resident #11s annual assessment, dated 09/01/25, showed their cognition was significantly impaired and was unable to participate in the BIMS assessment. The assessment showed Resident #4 was dependent for toileting and hygiene and required supervision or touching assistance for bed mobility. The assessment showed the resident required partial to moderate assistance with transfers and they used a wheelchair for mobility. The assessment showed Resident #4 had diagnoses which included type 2 diabetes, pseudobulbar affect, and bradycardia. On 09/23/25 at 2:51 p.m., Resident #4 stated Resident #11 was coming into their room and their closet. Resident #4 stated they requested to be moved rooms to prevent it from happening again and feels safe in the facility. On 09/24/25 at 10:41 a.m., family representative #3 stated they were notified Resident #5 was