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	01/08/2026

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 12/23/25 at 12:11 p.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy (IJ) situation related to the facility's failure to ensure a comprehensive care plan was developed for Resident #8 to prevent an elopement.Resident #8 was cognitively impaired with a BIMS score of 2. Resident #8 had two elopement assessments which identified Resident #8 as a moderate risk for elopement.Resident #8's care plan did not show elopement as a risk and did not contain any interventions.On 12/09/25, Resident #8 eloped from the facility. The resident was located nearby at a church with scratches. On 12/23/25 at 12:31 p.m., the administrator, DON, ADON, corporate nurse #1, dietary manager, and RDO were notified of the immediate jeopardy (IJ) situation and provided the IJ template.On 12/23/25 at 4:38 p.m., an acceptable plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal showed,a. Residents with an elopement score greater than 11 should have interventions in their care plan,b. Resident #8 was discharged from the facility on 12/19/25,c. the DON or designee will in- service all clinical licensed staff on completion of elopement risk assessment by 12/23/25 at 12:59 p.m. and staff unable to complete education will not be allowed to work until education is completed,d. an audit of all residents' elopement assessments will be completed by 12/23/25,e. the DON or designee will update all care plans for residents identified as a moderate or high elopement risk,f. the DON or designee will monitor elopement risk assessments completion quarterly with the MDS assessment completion and update the care plans,g. a QAPI committee was held on 12/23/25 to discuss the plan of removal,h. the medical director was notified of the immediate jeopardy on 12/23/25, [NAME]. the DON would track, tend, and analyze audit results and forward to the QAPI committee.On 12/23/25, the immediate jeopardy was lifted, when all components of the POR had been verified as corrected. a. Resident #8's health record was reviewed. The health record showed Resident #8 discharged from the facility to a different facility on 12/19/25,b. in-service documentation, dated 12/23/25, showed seventy-seven staff members were in-serviced over elopement policies, prevention, and care plans,c. seven residents' care plans, dated 12/23/25, were reviewed. The care plans showed seven residents' care plans were updated by 12/23/25 to ensure wandering and elopement risk had a focus and interventions to prevent elopement,d. two newly admitted residents' elopement assessments were reviewed. The assessments showed they were completed and residents were not an elopement risk, e. the off cycle QAPI notes, dated 12/23/25, were reviewed. The QAPI notes showed the facility had a meeting with the medical director and discussed all residents with a score of 11 or higher should be care planned for an elopement risk, andf. on 12/29/25, nine direct care staff were interviewed from multiple disciplines and shifts regarding in-service education over elopement procedures and updating the care plan. Staff were able to communicate they have been educated on elopement and care plan updating.The deficient practice remained at a pattern with the potential for more than minimal harm. Based on observation, record review, and interview, the (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility failed to ensure:a. a comprehensive care plan was developed to prevent elopement for 1 (#8) of 3 residents sampled for comprehensive care plans to prevent elopement; andb. a comprehensive care plan was developed for a resident requiring transferring assistance with a mechanical lift for 1 (#7) of 3 residents sampled for comprehensive care plans for lift assistance. The administrator identified seven residents were an elopement risk and 20 residents required a mechanical lift to transfer. Findings:1.On 12/22/25 at 3:30 p.m., the exterior of the facility was observed. The facility was located on a two-lane busy main street. There was an open golf course with ponds located adjacent to the facility. A facility policy titled Comprehensive Care Plans, revised 02/12/20, read in part, It is the policy of this facility to develop and implementation a comprehensive person-centered care plan for each resident, consistent with the residents rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment. A facility policy titled Elopement Management, dated 02/12/20, read in part, Document Requirements in the EHR: .Update the Care Plan.Resident #8's care plan, dated 02/06/25, from a previous EHR, no longer active, and not accessible to staff, showed a focus Resident #8 was exit seeking. The care plan interventions showed:a. analyze keys times, places and circumstances, triggers, and what deescalated behavior dated 05/30/24,b. encourage activities dated 02/06/25,c. frequent visual checks dated 02/06/25, d. maintain behavior log dated 02/06/25, ande. provide a pleasant home-like environment dated 02/06/25.Resident #8's elopement assessment, dated 08/19/25, showed the resident was scored as a moderate risk for elopement with a score of 19 Resident #'8s quarterly assessment, dated 08/25/25, showed their cognition was significantly impaired with a BIMS score of 2. The assessment showed Resident #8 was admitted on [DATE] with diagnoses which included schizophreniform disorder and chronic kidney disease. The assessment showed Resident #8 did not wander during the look back period. The assessment showed Resident #8 was independent for ambulating.Resident #8's elopement assessment, dated 11/20/25, showed the resident was scored as a moderate risk for elopement with a score of 16. A facility reported incident combined initial and final report, dated 12/09/25, showed Resident #8 was missing from the facility and found during a search. The report showed Resident #8 was found North of the building near a church parking lot with scratches on their elbow and was returned to the facility and placed on one-on-one supervision. The national weather service showed the temperature in [NAME], Oklahoma on 12/09/25 was 50 degrees Fahrenheit at 6:00 p.m.Resident #8's nursing note, dated 12/10/25, showed an unidentified CNA noticed Resident #8 was missing on 12/09/25 at 6:00 p.m. The note showed another unidentified resident admitted to letting Resident #8 out of the facility. The note showed the facility notified the family, police, and started to search for Resident #8. The note showed Resident #8 was located at 7:20 p.m. and returned to the facility. Resident #8's care plan, developed 12/10/25, showed a focus for elopement risk was added on 12/10/25. The care plan showed the following interventions:a. all staff were to be aware of high elopement risk and visually monitor the resident in the common areas and near exits,b. attempt to redirect the resident when they fixate on the exits, andc. signage placed at the primary entrance and exits to alert visitors of exit seeking residents. On 12/22/25 at 1:58 p.m., the DON was shown Resident #8's elopement assessments, dated 08/19/25 and 11/20/25. The DON stated Resident #8 was a moderate risk for elopement and the care plan should have a focus and interventions after the elopement assessments. The DON stated the facility went with a new EHR earlier in the year. The DON stated Resident #8 did not have a focus or interventions to address Resident #8's elopement risk from 06/12/25 through 12/10/25 because the old focus and interventions were never carried over to the new EHR and they did not follow their policy and update the care plan after the elopement assessments (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	showed Resident #8 was a moderate risk for elopement. On 12/23/25 at 8:36 a.m., CNA #2 stated they have their charting system, but it did not tell them all the details all the time. CNA #2 stated they went to the nurses and fellow aides to find out about residents at risk for elopement to learn about the care plan. CNA #2 stated they did not have access to the care plan. On 12/23/25 at 9:12 a.m., the DON stated Resident #8 eloped from the facility after being let out by another resident on 12/09/25. The DON stated Resident #8 was located a block away from the facility near a church and may have went across a golf course located adjacent to the facility. The DON stated the resident returned with scratches on their arm.2.Resident #7's quarterly assessment, dated 07/23/25, showed the residents cognition was intact with a BIMS score of 15. The assessment showed Resident #7 was admitted on [DATE] with a diagnosis of end stage renal disease. The assessment showed Resident #7 had lower extremity impairments, was dependent for dressing, toilet hygiene, and all transfers.An OSDH facility reported incident, dated 12/16/25, showed Resident #7 fell from the mechanical lift sling breaking during a transfer.Resident #7's hospital records, dated 12/16/25, showed Resident #7 was diagnosed with fracture of the left tibia and fracture of the right clavicle after a fall during transfer using a mechanical lift at the facility on 12/16/25.Resident #7s care plan, dated 12/22/25, did not have a focus or interventions for transfers prior to 12/22/25.On 12/22/25 at 3:28 p.m., corporate nurse #1 stated Resident #7's care plan did not have a focus for transferring. Corporate Nurse #1 stated transferring should be included in the care plan focus for residents who were dependent for transfers.On 12/22/25 at 3:30 p.m., the DON stated residents who required a lift to transfer should be included in the care plan. The DON stated Resident #7's care plan did not have any focus or intervention for transferring assistance prior to 12/22/25.On 12/23/25 at 8:19 a.m., Resident #7 stated two aides were helping them transfer with a lift from the bed to a wheelchair when the strap on one side of the sling broke and they fell from the lift. Resident #7 stated their shoulder and leg were broken when they fell. Resident #7 stated the staff had to feed them which was embarrassing. Resident #7 stated they had a brace on their leg, experienced a lot of pain, and was fearful of transfers. On 12/23/25 at 8:36 a.m., CNA #2 stated they were transferring Resident #7 with another aide present from the bed to a wheelchair with a mechanical lift and the white sling broke on one side resulting in Resident #7 falling from 3 feet in the air. CNA #2 stated Resident #7 hurt their left foot as they fell. CNA #2 stated they had their charting system, but they went to a nurse to learn about specific residents because they did not have access to the care plan.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** On 12/23/25 at 12:11 p.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy (IJ) situation related to the facility's failure to ensure Resident #7 was not dropped from a mechanical lift during a transfer.Resident #7's quarterly assessment, dated 07/23/25, showed their cognition was intact with a BIMS score of 15. The assessment showed Resident #7 was dependent for all transfers.A facility incident report, dated 12/16/25, showed Resident #7 had a fall from a mechanical lift on 12/16/25 when a sling broke resulting in a fracture to the right clavicle and the left tibia.On 12/23/25 at 12:31 p.m., the administrator, DON, ADON, corporate nurse #1, dietary manager, and RDO were notified of the immediate jeopardy (IJ) situation and provided the IJ template.On 12/23/25 at 4:38 p.m., an acceptable plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal showed,a. Resident #7 was sent to the hospital on [DATE] and returned to the facility for continued treatment,b. Resident #7s care plan was updated with interventions and focus to include transfers on 12/23/25,c. the DON or designee would perform audits of residents who required assistance with transfers using a mechanical lift and update care plans accordingly on 12/23/25,d. the DON or designee would reeducate nursing staff on choosing the proper slings and weight requirement on 12/23/25 at 06:00 p.m.,e. staff who did not receive education by 6:00 p.m., would not be allowed to work until educated,f. the medical director was notified of the IJ on 12/23/25,g. a QAPI meeting was held on 12/23/25 with the medical director, the facility administrator, and director of nursing to review the plan of removal, andh. the director of nursing would track, trend, and analyze audit results and forward results of audits monthly to the QAPI Committee for review and/or action. On 12/29/25, the IJ was lifted, when all components of the POR had been verified as corrected.a. on 12/16/25, in-service documentation, dates 12/23/25, showed sixty-three direct care staff were in-serviced over safe lift and transferring for dependent residents,b. on 12/29/25, nine direct care staff were interviewed from multiple disciplines and shifts regarding in-service education on transferring dependent residents safely. All staff were able to communicate understanding of proper lift and transfer policy and procedures to ensure dependent residents would be transferred safely,c. Resident #7's care plan, dated 12/24/25, was reviewed. The care plan showed a focus Resident #7 required a mechanical lift to transfer,d. eighteen dependent residents for transfers care plans were reviewed. The care plans showed they were updated to include lift and transfers focus and interventions on 12/27/25, ande. the off cycle QAPI notes, dated 12/23/25, were reviewed. The QAPI notes showed the facility had a meeting with the medical director and discussed education over slings and care plans being updated.The deficient practice remained at pattern with a potential for harm.Based on observation, record review, and interview, the facility failed to:a. safely transfer a dependent resident using a lift for 1 (#7) of 3 residents sampled for safe lifting and transfers; andb. provide adequate supervision to prevent elopement for 1 (#8) of 3 residents sampled for adequate supervision. The administrator identified 20 residents were dependent for mechanical lift transfers and seven residents were at risk for elopement. Findings:1. On 12/23/25 at 8:18 a.m., Resident #7 was observed in their bed. Resident #7 was observed receiving a breakfast tray on their bed side table from CNA #2. CNA #2 was observed telling Resident #7 they will assist Resident #7 with eating and placed the bed side table in front and over Resident #7's chest and abdomen area. A facility policy titled ADL [activities of daily living] Care -Transfer Techniques, revised 02/12/20, read in part, Staff will provide safe effective transfer techniques for residents in accordance to standard practice guidelines.Mechanical Lift (Hoyer/Sit to Stand) Utilize manufactures' guidelines.An undated facility (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	document for the care of slings titled Section1-General Guidelines, read in part, After each laundering in accordance with instructions on the sling), inspect sling(s) for wear, tears, and loose stitching.Resident #7's quarterly assessment, dated 07/23/25, showed Resident #7's cognition was intact with a BIMS score of 15. The assessment showed Resident #7 was admitted with end stage renal disease, had lower extremity impairments, was dependent on staff for all transfers.An OSDH facility reported incident, dated 12/16/25, showed Resident #7 fell from left sling breaking during a transfer resulting in a fracture to the right clavicle and the left tibia.Resident #7's hospital records, dated 12/16/25, showed Resident # 7 was diagnosed with fracture of the left tibia and fracture of the right clavicle after a fall during a transfer using a mechanical lift at the facility on 12/16/25.Resident #7's nursing note, dated 12/16/25, read in part, 11:00- resident was being transferred from the bed to w/c [wheelchair] when [they] fell out of sling onto the floor. [They] had landed on the back of [his] head, bilateral shoulders, bilateral hips and left knee where [they] has c/o [complained of] pain.Resident #7s care plan, dated 12/22/25, did not have a focus or interventions for transfers on 12/16/25 when the accident occurred.On 12/23/25 at 8:19 a.m., Resident #7 stated two aides were helping them transfer with a lift from the bed to a wheelchair when the strap on one side of the sling broke and they fell from the lift. Resident #7 stated their shoulder, and leg was broken when they fell. Resident #7 stated the staff had to feed them due to their broken clavicle and not being able to use their arms which was embarrassing. Resident #7 stated they had a brace on their leg, experienced a lot of pain, and was fearful of transfers. On 12/23/25 at 8:36 a.m., CNA #2, stated they went to the laundry to get a sling because the blue sling Resident #7 usually had one in their room that was not available. CNA #2 stated they had bigger and smaller sizes. CNA #2 stated they got a medium white colored sling based upon their best judgement if it would fit the resident and they just guessed what size to use. CNA #2 stated they did not usually check for sizes. CNA #2 stated they were never trained on how to determine what size sling to use. CNA #2 stated the DON told them the white slings were disposable and should not have been used. CNA #2 stated they were transferring Resident #7 with another aide present from the bed to a wheelchair with a mechanical lift and the white sling broke on one side resulting in Resident #7 falling from 3 feet in the air. CNA #2 stated Resident #7 hurt their left foot as they fell. CNA #2 stated they did not know the white slings were disposable and did not understand why they would have been hanging in the laundry room. On 12/23/25 at 9:12 a.m., the DON stated the slings were kept in a resident's room unless they were soiled. The DON stated an aide went to the laundry room and grabbed a medium size sling which was appropriate for the resident's weight. The DON stated the strap on the sling broke while two aides were transferring Resident #7. The DON stated they did not specify sling sizes because residents weight changes and the slings have the weight on them. The DON stated residents are weighed monthly and that was how the aides who were trained determined the sling to use. The DON stated the correct sling was used and the only reason a disposable sling would have been in the laundry room was if a resident came back from the hospital with one. 2.On 12/22/25 at 3:30 p.m., the exterior of the facility was observed. The facility was located on a two-lane busy main street. There is a golf course with ponds located adjacent to the facility. A facility policy titled Elopement Management, dated 02/12/20, read in part, Document Requirements in the EHR: .Incident/Accident report, .Nursing Notes should reflect an accurate account of the situation and outcome.Social Services note needs to address emotional account of the situation and outcome.Update the elopement Risk Assessment .Update the Care Plan.Resident #8's care plan, dated 02/06/25, showed a focus that Resident #8 was exit seeking. The care plan interventions showed:a. analyze keys times, places, circumstances, triggers, and what deescalated behavior dated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/30/24,b. encourage activities dated 02/06/25,c. frequent visual checks dated 02/06/25, d. maintain behavior log dated 02/06/25, ande. provide a pleasant home-like environment dated 02/06/25.Resident #8's elopement assessment, dated 08/19/25, showed the resident was scored as a moderate risk for elopement with a score of 19.Resident #'8s quarterly assessment, dated 08/25/25, showed their cognition was significantly impaired with a BIMS score of 2. The assessment showed Resident #8 was admitted on [DATE] with diagnoses which included dementia with behavior disturbances and chronic kidney disease. The assessment showed Resident #7 did not wander during the look back period. The assessment showed Resident #8 was independent for ambulating.Resident #8's elopement assessment, dated 11/20/25, showed the resident was scored as a moderate risk for elopement with a score of 16.A facility reported incident combined initial and final report, dated 12/09/25, showed Resident #8 missing from the facility and found during a search. The report showed Resident #8 was found North of the building near a church parking lot with scratches on their elbow and was returned to the facility and placed on one-on-one supervision. The national weather service showed the temperature in [NAME], Oklahoma on 12/09/25 was 50 degrees Fahrenheit at 6:00 p.m.Resident #8's nursing note, dated 12/10/25, showed an unidentified CNA noticed Resident #8 was missing on 12/09/25 at 6:00 p.m. The note showed another unidentified resident admitted to letting Resident #8 out of the facility. The note showed the facility notified the family, police, and started to search for Resident #8. The note showed Resident #8 was located at 7:20 p.m. and returned to the facility. Resident #8's care plan, revised 12/10/25, showed Resident #8 had a focus added for being an elopement risk. The care plan showed Resident #8 had interventions added to the care plan to address elopement on 12/10/25:a. staff was to be aware of Resident #8 in common area and visually monitor them,b. attempt to redirect the resident when they fixated on exits, andc. signage placed on exits to alert visitors of exit seeking residents. Resident #8's care plan, revised 12/10/25, did not have a focus and interventions to address Resident #8's elopement risk and did not have interventions for increased supervision from the previous care plan dated 02/06/25. On 12/22/25 at 1:58 p.m., the DON was shown Resident #8's elopement assessments, dated 08/19/25 and 11/20/25. The DON stated Resident #8 was a moderate risk for elopement and the care plan should have a focus and interventions after the elopement assessments. The DON stated the facility went with a new EHR earlier in the year. The DON stated Resident #8 did not have a focus or interventions to address Resident #8's elopement risk and need for increased supervision from 06/12/25 through 12/10/25 because the old focus and interventions from the care plan, dated 02/06/25, were never carried over to the new EHR and they did not follow their policy and update the care plan after the elopement assessments showed Resident #8 was a moderate risk for elopement. On 12/23/25 at 8:36 a.m., CNA #2 stated Resident #8 would always watch the doors and exit seek for the last few months. On 12/23/25 at 9:12 a.m., the DON stated Resident #8 eloped from the facility after being let out by another unidentified resident on 12/09/25. The DON stated Resident #8 was located a block away and may have cut across the golf course which was adjacent to the facility to a nearby church where they were located. The DON stated Resident #8 had scratches to their arms when they returned to the facility.