OKLAHOMA
State Department
of Health

Delivery via email to: nwgbnh@gmail.com

June 20, 2023

License Number: AL2405

Ms. Natasha Willson, Administrator
Greenbrier Village Residential Living, Llc
1217 E Garriott
Enid, OK 73701

RE: Survey Event ID: 14JR11

Dear Ms. Willson:

On **May 31, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on May 31, 2023.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2405	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER VILLAGE RESIDENTIAL LIVING, LLC	1217 E GARRIOTT ENID, OK 73701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A re-licensure survey was conducted from 05/30/31 to 05/31/23. Listed below are abbreviations that will be used throughout this document. DON- DIRECTOR OF NURSING ER- EMERGENCY ROOM HTN- HYPERTENTION OSDH- OKLAHOMA STATE DEPARTMENT OF HEALTH RN- REGISTERED NURSE.	C 000		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were coordinated by an RN or physician for three (#2, 4, and #6) of eight residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 43 residents resided in the facility. Findings: 1. Resident #6's preadmission "Resident Assessment Form" dated 07/06/22, documented signature from one participating health professional. No signature from an RN or physician was documented on the form.	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 542	Continued From page 1 2. Resident #2 admitted with diagnoses which included HTN, alcohol abuse, repeated falls, urine retention, and recurrent depressive disorder. A OSDH "Recommended Assisted Living Resident Assessment Form", documented the assessment date of 04/03/23 was a 14-day assessment. There was no RN or physician signature noted on the form. 3. Resident #4 admitted with diagnoses which included Dementia and mood disorder. A OSDH "Recommended Assisted Living Resident Assessment Form", documented the assessment date of 07/02/22 was an Annual assessment. There was no RN or physician signature documented on the form. On 05/31/23 at 10:25 a.m., the DON was shown resident # 2's review worksheet RN/Physician signature line that had the date of 04/03/23 with no signature on it. The DON was asked if it was signed by the RN or physician. They stated, no. They were asked if it should have been signed. They stated, yes. On 05/31/23 at 10:49 a.m., the DON stated they had not signed/coordinated the preadmission and the 14 day form for Resident #6 and the document should have been signed by either the Physician or an RN. The DON confirmed Resident #4's annual assessment had not been signed by a RN or physician.	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 2	C1911		
C1911 SS=E	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure reportable incidents were reported to OSDH within one business day for the initial report and no more than 10 days for the final report for two (#9 and #10) residents reviewed for incident reports.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 3 The Administrator identified 43 residents resided in the facility. Findings: An "Incident Reports" policy, amend 10-02-2014, read in parts, "...Administrator and Director of nursing will also verify reportable incidents and coordinate department guidelines, Time frame, and five day follow up...Time Frames...1. One department business day for initial report 2. Follow up in five days 3. Final report not to exceed 10 days." 1. Resident #9 had diagnoses which included dementia, mood disturbance, and anxiety. A facility "Incident Report," form dated 02/04/23 at 7:22 p.m., documented Resident #9 had fallen and hit their head. It documented resident was sent to the hospital. An OSDH " Incident Form," dated 02/04/23, marked for the initial report, documented Resident #9 had fallen and was sent to the ER. A facsimile "confirmation report," dated 02/10/23 at 12:44 p.m., documented Resident #9's reportable incident had been reported to OSDH five business days after the incident. A facility "Incident Report," form dated 02/07/23 at 9:51 p.m., documented Resident #9 had fallen and had hit their head. The resident was not taken to the ER. An OSDH "Incident Form," dated 02/07/23, marked for the initial report, documented Resident #9 had fallen.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2405	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER VILLAGE RESIDENTIAL LIVING, LLC	1217 E GARRIOTT ENID, OK 73701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1911	Continued From page 4 A facsimile "confirmation report," dated 02/10/23 at 12:39 p.m., documented Resident #9's reportable incident had been reported to OSDH three business days after the incident. 2. Resident #10 had diagnoses which included HTN, femur fracture, and dementia. A facility "Incident Report," dated 05/14/23 at 6:45 a.m., documented Resident #10 was found on their bathroom floor and the resident was unable to talk or move their right side. It documented they were sent to the hospital. An OSDH "Incident Report Form," dated 5/14/23, documented Resident #10 was found on their bathroom floor unable to talk to staff. It documented the resident was sent to the ER for treatment. A facsimile "confirmation report," dated 05/30/23., documented Resident #10's reportable incident had been reported to OSDH 12 business days after the incident. On 05/31/23 at 12:50 p.m., the Administrator was asked what the reporting timeframe requirement was for an initial and final reports to OSDH. They stated one business day for initial and five days for the final. The Administrator was shown the three state reportable incident forms to review. On 05/31/23 at 12:55 p.m., the Administrator was asked if the reports shown were reported according to OSDH regulation. They stated, no they were not.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: nwgbnh@gmail.com

July 3, 2023

License Number: AL2405

Ms. Natasha Willson, Administrator
Greenbrier Village Residential Living, Llc
1217 E Garriott
Enid, OK 73701

RE: Survey Event 14JR11

Dear Ms. Willson:

On **May 31, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 26, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/29/2023
Facility Name: Greenbrier Village Residential Living L.L.C
License Number: AL2405
Survey Event ID: 14JR11
Date Survey Completed: 5/31/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542	Based on: The facility failed to ensure assessments were coordinated by an RN or physician for three (#2, 4, and #6) of the eight residents reviewed for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	#6 resident preadmission assessment form did not have a RN or physician signature documented on form. #2 resident 14 day assessment did not have a RN or physician signature documented on form. #4 resident annual assessment did not have a RN or physician signature documented on form.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Facility will use Assessment Grid & Administrator QA as a guideline. See Attachments 1&2.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Administrator will monitor assessment grid and mark on Administrator QA. See Attachment 1&2.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Administrator to monitor Assessement grid daily. Will monitor Attachment 1 daily Will go over all assessments in Quality Assurance meeting monthly. Attachment 3 Will reflect on Administrator QA as well as the assement grid. Attachments 2&1.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Natasha Willson** Natasha Willson **Date 6/29/2023**
OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

ATTACHMENT ①

PROCESS:

1: AL ADMIN INPUT RESIDENT NAMES

2: RN ON RECORD COMPLETE, FILL IN DATE COMPETED AND NOTIFY AL ADMIN

3: AL ADMIN PROOF, SIGN OFF AND NOTIFY PAYROLL

NAME ASSESSMENT	NAME CARE PLAN	DATE COMPLETE	RN INITIALS	ADM INITIALS	RATE/ASSESSMENT	ADMIN INI	TOTAL COST
							$ -
							$ -
							$ -
							$ -
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							$ -
TOTAL COST							$ -

ATTACHMENT (2)

Greenbrier Assisted Living Administration

8:00-4:30

GOAL for AL, just as Homes: CUSTOMER SERVICE our staff, our visitors, families and residents.... This can be one of the most rewarding days of your week schedule!!!

8:00- 8:30 : Check with MAT's first if they need any help with anything?(*If a Mat is out, help out as CNA) List what you helped them with

Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____

2nd: Check with Dietary: anything they need help with? (*If a Dietary Aide is out, help with that position)

Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____
Date: _____ Employees_____ Assisted the with:_____

Monitor the Screener QA: fill out the observation portion at end of QA

8:30 – 9:00- Meet with DON after your rounds/ her rounds(Attendance to be Admin, Nurse, Dietary manger, Activities director)

Monday	Tuesday	Wednesday	Thursday	Friday
DON: Activity/BLD: Dietary:				

Monitor Assessment Grid Weekly:

Date:	Resident done:	State if it is a Preadmission assessment/Annual assessment/ 14 day/ Significate Change

9:00-10:00 a.m. Rounds to see all the residents.

While on rounds, check on Housekeepers/ Maintenance:

10:00-10:15am List time/ any comments or follow up. *If a grievance asks to put in writing to Kay Grey

Say good morning to Dietary Manager, notice staffing ok
Say good morning to Customer Care Director, ask any tours, events

ATTACHMENT (3)

II. Medically Social Work Related Services: (List name of Resident receiving: new:

Jan
Feb
March
April
May
June
July
Aug
Sept
Oct
Nov
Dec

I. Bring a copy of the criteria:

II. Bring a list of any residents with UTI, URI....infection control:

III. Bring a list of any residents who have fallen and any report of the review of the fall/intervention:

III. Review RN; all care plan, assessments, pharmacy signed: of Nurse Consultant Report:

Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**

MAT training effectiveness & needs: Kim

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

VIII. Administration
A. INCIDENT Report:

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

Incident Reports....any turned into state
Administrator Bring:
G. Speed messages &follow up list from Dept. Meeting
H. Requests for change, staffing, forms, services, procedures
I. Report from local, state& federal agencies

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/29/2023** **Facility Name:** Greenbrier Village Residential Living L.L.C **License Number:** AL2405 **Survey Event ID:** 14JR11 **Date Survey Completed: 5/31/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911	Based on: The facility failed to ensure reportable incidents were reported to OSDh with in one business day for the initial report and no more than 10 days for the final report for two (#9 and #10) residents reviewed for incident reports.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	#9 resident did not have a timely initial report within 1 business day. See attachments (1) incident reporting grid (2 &3) Administrator QA. #10 resident did not have a timely initial report within 1 business day. See attachements (1) incident reporting grid & Attachments (2&3) Administrator QA.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Facility will use Administrator QA and incident reporting grid as a guideline. See attachments 1,&2.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Administrator will monitor incident reports and mark on Administrator QA. See Attachment 2.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Nurse to monitor incident reporting grid daily. Nurse and Administrator will monitor Attachment 1 daily. Will go over all incidents in Quality Assurance meeting monthly. Attachment 3 Will reflect on Administrator QA as well as the incident reporting grid. Attachment 1, & 2.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Natasha Willson** Natasha Willson OAC 310:663-25-4(F)	**Date 6/29/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

ATTACHMENT (1)

Incident reporting grid						
Resident	Master calendar documented	Initial report date	Director of Nursing initials for initial report	5-day final report date	Director of Nursing initials for 5 day	Other

ATTACHMENT (2)

Say good morning to DON, notice if staffing hired up/ schedule covered for week
Any issues she needs help with. **Check nurse QA daily.**

10:15-10:30 Break time.

10:30-11:30 Administrator office duties: *One-hour office

1.Check hours daily prevent overtime/ within budget.

Monday	Tuesday	Wed	Thurs	Friday

2. Look 7 days ahead at the schedule to see that schedule good for nursing, dietary, hk, events

Date:	Date:	Date:	Date:	Date:

3. Do any reports for State of OK/ incidents

Date:	Date:	Date:	Date:	Date:

4. Stand up meeting: any notes to share:

Date:	Date:	Date:	Date:	Date:

*Criteria Grid: Intervention/Accommodation

11:30-12:00 –Be in the dining room during serving time to monitor the hospitality Aides.

Look for staying on task _____

Look over QA _____

Look at cleaning the schedule _____

12:00-12:30- Lunch Break:

12:30-2:00- Administrator office duties:

5. Email and call HR when need to hire employee or would like HR to come over and help with investigation of Grievance

Monday	Tuesday	Wed	Thur	Friday

6. Mail in and out

Date:	Date:	Date:	Date:	Date:

7. Admissions

Monday	Tuesday	Wed	Thur	Friday

ATTACHMENT (3)

II. Medically Social Work Related Services: (List name of Resident receiving: new:

Jan
Feb
March
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Oct
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I. Bring a copy of the criteria:

II. Bring a list of any residents with UTI, URI....infection control:

III. Bring a list of any residents who have fallen and any report of the review of the fall/intervention:

III. Review RN; all care plan, assessments, pharmacy signed: of Nurse Consultant Report:

Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**

MAT training effectiveness & needs: Kim

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

VIII. Administration
A. INCIDENT Report:

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

Incident Reports....any turned into state

Administrator Bring:
G. Speed messages &follow up list from Dept. Meeting
H. Requests for change, staffing, forms, services, procedures
I. Report from local, state& federal agencies

OKLAHOMA
State Department
of Health

Delivery via email to: nwgbnh@gmail.com

October 20, 2023

License Number: AL2405

Ms. Natasha Willson, Administrator
Greenbrier Village Residential Living, Llc
1217 E Garriott
Enid, OK 73701

RE: Survey Event 14JR12

Dear Ms. Willson:

On **August 28, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 31, 2023,** have now been corrected effective **July 26, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
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Oklahoma State Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2405	A. BUILDING: _____ B. WING _____	R 08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER VILLAGE RESIDENTIAL LIVING, LLC	1217 E GARRIOTT ENID, OK 73701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/28/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE