OKLAHOMA
State Department
of Health

Delivery via email to: nwgbnh@gmail.com

November 6, 2025

License Number: AL2405

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

RE: Survey Event ID: V23T11

Dear Ms. Willson:

On **October 29, 2025**, 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 **October 29, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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: IDRCoordinator@health.ok.gov

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.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Greenbrier Village Residential Living**
Address: **1217 E. Garriott**
City, State, Zip: **Enid, OK 73701**
Provider #: **AL2405**
Complaint #: **OK00077337**
Investigation Date(s): **10/28/25 and 10/29/25**

ALLEGATIONS
The facility failed to ensure medications were ordered and available to administer in a timely manner.
The facility failed to ensure staff intervened when a resident continued to complain of pain.

An unannounced on-site investigation was initiated 10/28/2025 at 9:33 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Staff were observed assisting residents with their needs. Staff were observed interacting with residents.

Resident records were reviewed including assessments, care plans, physician orders, progress notes, treatment records, and activities of daily living (ADL) records. Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Residents were interviewed in regard to medication administration and pain control. Staff were interviewed on medication ordering, administration, and policies.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

OKLAHOMA
State Department
of Health

Date report completed: 10/29/2025

Oklahoma State Department of Health

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 _____	C 10/29/2025

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 relicensure survey with complaint (#OK00077337) was conducted on 10/28/25 through 10/29/25. Deficiencies were cited as a result of the survey. Facility Census: 46 Listed below is a list of abbreviations that will be used throughout this document. DON- director of nursing HCL- hydrochloride MAR- medication administration record MAT- medication administration technician	C 000		
C 324 SS=D	310:663-3-3(a)(4) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (4) medication administration; This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a resident received eye drop medication as ordered for 1 (#1) of 8 sampled residents whose medications were reviewed. The "Entrance Conference Checklist," dated 10/28/25 showed a census of 46.	C 324		

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 _____	C 10/29/2025

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

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C 324	Continued From page 1 Findings: An undated order summary showed Resident #1 had diagnoses of glaucoma and conjunctivitis. A physician order, dated 10/08/24, showed dorzolamide (eye drops for glaucoma) hcl ophthalmic solution 2% one drop in left eye three times a day related to unspecified glaucoma. A physician order, dated 02/10/25, showed polytrim (antibiotic eye drop) ophthalmic solution 10000-0.1 unit/milliliter % one drop in both eyes three times a day related to other conjunctivitis. Review of the Feburary 2025 MAR record showed: a. two blanks for the dorzolamide hcl. on 02/08/25 at 2:00 p.m. and on 02/18/25 at 2:00 p.m., and b. one blank for the polytrim on 02/18/25 at 2:00 p.m. On 10/29/25 at 3:31 p.m., MAT #5 reviewed the MAR and stated Resident #1 did not receive the dorzolamide hcl on 02/08/25 at 2:00 p.m. or on 02/18/25 at 2:00 p.m. They stated Resident #1 did not receive the polytrim on 02/18/25 at 2:00 p.m. On 10/29/25 at 4:05 p.m., the DON stated the blank boxes on the MAR meant the medications were not given. On 10/29/25 at 4:07 p.m., the DON stated after review of the Feburary 2025 MAR, it did not look like the dorzolamide hcl on 02/08/25 at 2:00 p.m., and 02/18/25 at 2:00 p.m., and the polytrim on 02/18/25 at 2:00 p.m., were given. On 10/29/25 at 4:14 p.m., the DON stated neither	C 324		

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 _____	C 10/29/2025

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 324	Continued From page 2 medications were administered as ordered and should have documented refused.	C 324		

OKLAHOMA
State Department of Health

Delivery via email to: nwgbnh@gmail.com

November 14, 2025

License Number: AL2405

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

RE: Survey Event V23T11

Dear Ms. Willson:

On **October 29, 2025**, 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 in a timely manner. **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 **December 22, 2025**.

We will conduct a revisit 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, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/13/2025** **Facility Name:** Greenbrier Village Residentail Living LLC **License Number:** AL2405 **Survey Event ID:** V23T11 **Date Survey Completed: 10/29/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 324	Based on: record review and interview, the centerfailed to ensure a resident received eye dropmedication as ordered for 1 (#1) of 8 sampled residents whose medications were reviewed.

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?	Evidenced by medication given per physicains orders
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON will monitor EMARs daily. Administrator will monitor Emars weekly as well as check DON QA weekly.
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?	Will have inservice on 11/20/2025 to train, and educate staff on the PIG method, & policies that Greenbrier has on Medication administration. Will discuss in (GM) Quality assurance meeting on 12/4/25.
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.	DON will monitor EMARs daily. Administrator will monitor Emars weekly as well as check DON QA weekly. DON will monitor EMARs daily. Administrator will monitor Emars weekly as well as check DON QA weekly. Will discuss in (GM) Quality assurance meeting on 12/4/25. As evidenced by Emar and POC, as well as QA's kept on file by administrator.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/22/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 11/13/2025**	

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.

7a-3p CNA/MAT QA

2:30-2:55-Documentation

Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Check Emar								ADL'S							
Prn charting								Comm. Log							

2:55-3:00 (Make sure that all empty pill cards are replaced with full ones and old ones are thrown away.)

2:45-3:00 Count narcotics with off going shift. Get report from off going shift as both on going and off going MAT walk hall checking on residents list any problems---------- ❒ Sun ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat

Date	Resident	Problems

MED CART KEYS ARE NEVER TO LEAVE THE BUILDING, EVEN FOR BREAKS

Day	Person you counted on with	Day	Person you counted off with
Sun		Sun	
Mon		Mon	
Tue		Tue	
Wed		Wed	
Thur		Thur	
Fri		Fri	
Sat		Sat	

Please list here if any of your residents are having problems with doing their own FSBS, breathing Tx, or seem to be requiring more help than they should with their ADL's or other problems that we need to be aware of.

_____

_____

_____

_____

_____

_____

_____

_____

Signature:_____

3p-11p CNA/MAT QA

Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Check Emar								ADL'S							
Prn charting								Comm. Log							

10:30 Clean top of Med Carts, Stock Med Carts. Remove trash & put new trash bags in.--------❒ Sun ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat
(Make sure that all empty pill cards are replaced with full ones and old ones are thrown away.)

10:00-10:45 Count narcotics with off going shift. Get report from off going shift as both on going and off going MAT walk hall checking on residents list any problems---------- ❒ Sun ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat

Date	Resident	Problems

MED CART KEYS ARE NEVER TO LEAVE THE BUILDING, EVEN FOR BREAKS

Day	Person you counted on with	Day	Person you counted off with
Sun		Sun	
Mon		Mon	
Tue		Tue	
Wed		Wed	
Thur		Thur	
Fri		Fri	
Sat		Sat	

Please list here if any of your residents are having problems with doing their own FSBS, breathing Tx, or seem to be requiring more help than they should with their ADL's or other problems that we need to be aware of.

NOTES:_____

_____

_____

_____

_____

_____

Signature:_____

11p-7a CNA/MAT QA

Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Documented	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Check Emar								Meal %							
ADL'S								Comm. Log							
Med Fridge Temp															

5:00 Start Med Pass. Record FSBS, etc... ----------❒ Sun ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat

6:30 Make sure Residents are up and ready for breakfast. Help assigned resident get dressed for the day.

Date	Resident	Date	Resident	Date	Resident

6:45 Count narcotics with off going shift. Get report from off going shift as both on going and off going MAT walk hall checking on residents list any problems---------- ❒ Sun ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat

Date	Resident	Problems

MED CART KEYS ARE NEVER TO LEAVE THE BUILDING, EVEN FOR BREAKS

Day	Person you counted on with	Day	Person you counted off with
Sun		Sun	
Mon		Mon	
Tue		Tue	
Wed		Wed	
Thur		Thur	
Fri		Fri	
Sat		Sat	

Please list here if any of your residents are having problems with doing their own FSBS, breathing Tx, or seem to be requiring more help than they should with their ADL's or other problems that we need to be aware of.

_____

_____

Signature:_____

Assisted Living Nurse QA

Days: Hours:

DAILY	Mon	Tues	Wed	Thurs	Fri	Notes
Week 1						
Check on Staff and look over communication log						
Determine priority to return dr call see a certain resident before calling a family member.						
All Staff Stand up meeting: See agenda and notebook						
Adjust any priority or follow up list						
Make rounds at lunch café time/ visit with residents/ observe staff MAT process						
Lunch Break						
Office work: Call doctor, follow up orders, Check for Mar gaps						
Update Infection Control book						
Update Lab Book						
Update Fall Book						
Afternoon Stand up meeting						
Check for 14 Day Assessments due						
Check for any Annual Assessments due						
Check For any significate Changes needing assessment						
Update Fall Book						
Afternoon Stand up meeting						
Check for 14 Day Assessments due						
Check for any Annual Assessments due						
Check For any significate Changes needing assessment						

Weekly	
Week 1 Arrowhead and blue bird Week 3 Calico and Dreamland residents Check Care Plans. Calendar: Print list who is due	
Week 2 Arrowhead and blue bird Week 4 Calico and Dreamland Check Med Carts (clean, organized, etc.)	
Order nursing supplies on Friday – Give list to Natasha for Monday order	
Diabetic nail Care	

Monthly	
Last Week: RN print order summaries and sign DR orders	
Last Week: Monthly Labs	
Both Destroy Meds (second Week) day both in house	

Quarterly	
Both review Pharmacy Report	
Both destroy Narcotics with Pharmacist	

Administrator QA

6. Email and call HR when need to hire employee or would like HR to come over and help with investigation of Grievance. Set up time and write down.

Date:	Date:	Date:	Date:	Date:

7. Mail in and out

Date:	Date:	Date:	Date:	Date:

8. Admissions (check Admission QA done, follow Admissions next day, one week, Schedule one month: conference? Could be QA/DON)

Date:	Date:	Date:	Date:	Date:

9. Stand up meeting:

Date:	Date:	Date:	Date:	Date:

10. Look at Nurses QA. after standup with QA Director

Date:	Date:	Date:	Date:	Date:

11. Check EMAR for med errors.

Monday	Friday

Lunch break

Check with MAT's first if they need any help with anything?(*If a Mat is out, help out as CNA)

Date:	Date:	Date:	Date:	Date:

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

Date:	Date:	Date:	Date:	Date:

Arrowhead resident's week 1

Blue bird resident's week 2

Calico residents' week 3

Dreamland resident's week 4

QA GM Management Meeting

Flow Sheets (ADL'S) completed:

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
7-3												
3-11												
11-7												

MAR completed (Mar & Tar):

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
7-3												
3-11												
11-7												

Dr. Orders

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

Closed Records

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

Follow up from previous month: Nursing corrected items from last month:

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

Charts: Any Patterns

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

Status of each desk: Organization, Functional, Clean, etc.

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

III. Grievances:

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

OKLAHOMA
State Department of Health

Delivery via email to: nwgbnh@gmail.com

December 26, 2025

License Number: AL2405

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

RE: Survey Event V23T12

Dear Ms. Willson:

On **December 26, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 29, 2025,** have now been corrected effective **December 22, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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-C 12/26/2025

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 12/26/25. 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