

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Broadway Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1622 East Broadway Muskogee, OK 74403	

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)
<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure resident's rights to receive visitors of the resident's choice for one (#1) of three residents reviewed for visitation.</p> <p>The DON reported the census was 71.</p> <p>Findings:</p> <p>A Visitation Policy, revised 02/17, read in part, .Our facility permits residents to receive visitors subject to the resident's wishes .The facility provides 24-hour access to all individuals visiting with the consent of the resident .</p> <p>Resident #1 had diagnoses which included hypertension and anxiety disorder.</p> <p>A progress note, dated 03/25/24 at 2:19 pm, documented that a friend of Resident #1 called and wanted to visit the resident. The note further documented the facility contacted Resident #1's POA and the POA did not want the friend to visit. The note also documented that the friend was called back by the facility and informed the POA did not want him to visit.</p> <p>A progress note, dated 04/03/24 at 9:26 am, documented that a friend of Resident #1 called and wanted to visit the resident. The note further documented the facility contacted Resident #1's POA and the POA instructed the facility to call the police if the friend tried to visit Resident #1. The note also documented that the resident was notified that the friend would not be allowed to visit.</p> <p>On 07/10/24 at 1:30 pm, LPN #1 stated the facility should not restrict visitation based on the wishes of the POA.</p> <p>On 07/10/24 at 1:40 pm, the SSD stated that after they had the care plan meeting last week, they are no longer restricting Resident #1's visitors.</p> <p>On 07/10/24 at 1:50 pm, the DON stated that the ombudsman had informed them during the care plan meeting last week that the facility could not restrict visitation based on the wishes of the POA.</p> <p>On 07/10/24 at 2:17 pm, the Corporate Administrator stated they could not restrict visitation based on the wishes of a POA.</p>

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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