

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  11/21/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47453</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from abuse for one (#1) of three sampled residents reviewed for abuse.</p> <p>The administrator identified 75 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse Prevention policy, revised 10/21/22, read in part, The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: visitors, and any other individual Abuse: The willful infliction of injury, unreasonable confinement, intimidation with refusing physical harm, and pain. Abuse may be visitor-to-resident.</p> <p>1. Resident #1 had diagnoses which included anxiety, repeated falls, nicotine dependence, and alcoholic polyneuropathy.</p> <p>A Quarterly Resident Assessment, dated 11/13/24, documented Resident #1's cognition was severely impaired. It documented the resident made themselves understood and was able to understand others.</p> <p>A Incident Report OSDH form, dated 11/18/24, read in part, At approximately 3:45 a.m. resident noted yelling out from room, nurse immediately went to room and noted resident being physically restrained by roommates [visitor]. Nurse immediately told [visitor] to let go of resident right now. [Visitor] let go and stated no [they] is fine, [they] fine. Staff escorted resident [Resident #1] out of room and to nurses desk, assessments for pain and skin done immediately. Staff offered resident a new room and resident declined. Staff went to room and told visitor they would have to leave facility, visitor refused to leave and local police were called. Police escorted visitor out of building.</p> <p>A 911 service detail report, dated 11/18/24 at 4:18 a.m., read in part, when [visitor]refused the roommate attempted to get a nurse to remove [visitor]] and the [visitor] held the roommate down and refused to let them leave the room .subject was being loud and .[Resident #1] asked [visior] to leave.</p> <p>(continued on next page)</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Alert Note dated 11/18/24 at 5:22 a.m., read in part, At approximately 3:45a.m. resident noted yelling out from room, nurse immediately to room and noted resident being physically restrained by roommate's [visitor]. Nurse immediately told visitor to let go of resident right now. [Visitor] let resident go and stated, No, no [they are] fine [they] fine. [They are] ok. Escorted resident to nurses desk, assessments done .Verbal altercation per resident occurred, resident attempted to eave room. That's when [visitor] physically tried to restrain resident from leaving the room per residents statement. This nurse noted that resident was standing up next to doorway when [visitor] was noted holding both arms. This nurse asked resident if [they] would like a new room to go to. Declined new room, stating that [they] wanted to stay in [their] current room. This nurse [sic] residents' room, educated [visitor] that [they] needed to leave the building. [visitor] refused to leave room. ADON and DON notified. Police were called. [Visitor] escorted by police from [facility name withheld]. Skin and Pain assessment.</p> <p>On 11/20/24 at 2:24 p.m., Resident #1 was interviewed and stated their roommate had a visitor come into the facility to visit around 3:45 a.m. The resident stated the visitor was being loud in their room and they asked the visitor to not be so loud. The resident stated the visitor was asked several times and would not be quite. The resident stated they got up from their bed to get staff for help and the visitor grabbed both of their wrists at the doorway and would not let go. The resident stated staff heard them yelling for help and came immediately. The resident stated the visitor was not twisting their wrists, just holding both of them.</p> <p>On 11/21/24 at 5:24 a.m., CNA #1 was interviewed regarding the incident that occurred on 11/18/24 between Resident #1 and their roommates visitor. CNA #1 stated they heard LPN #1 telling the visitor of the roommate they would need to leave the facility. CNA #1 stated they heard Resident #1 saying the visitor pulled them away from the door to prevent them from leaving. CNA #1 stated then the police came.</p> <p>On 11/21/24 at 5:33 a.m., LPN #1 was interviewed regarding the incident that occurred on 11/18/24. LPN #1 stated a visitor of Resident #1's roommate came in about 3:40 a.m. and went to their room. LPN #1 stated they kept hearing Resident #1's voice. LPN #1 stated they went to the room and the roommate's visitor had Resident #1 by their wrist at the doorway. LPN #1 stated the visitor was not letting Resident #1 leave the room. LPN #1 stated they escorted Resident #1 to the nurses desk for safety. LPN #1 stated they did offer another room to Resident #1 and the resident declined another room. LPN #1 stated they went back to the room and told the visitor they would have to leave the facility and the visitor refused. LPN #1 stated they then called the police, DON, and ADON. LPN #1 stated the police got to the facility quick and escorted the visitor out of the building.</p> <p>On 11/21/24 at 9:21 a.m., the DON was asked what was the facility policy for abuse. The DON stated they were to report abuse immediately, call the police, APS, and the family. The DON was asked about the incident on 11/18/24 regarding Resident #1 and roommates visitor. They stated the roommate's visitor was not allowed back in facility at this time and had not been back since incident happened. The DON also stated the facility changed all the codes to entrance and exit doors and an in person inservice was completed regarding aggressive visitors.</p>		