| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375146 | A. Building<br>B. Wing | 05/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Broadway Care & Rehab Center | 1622 East Broadway<br>Muskogee, OK 74403 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/21/25, the OSDH determined an IJ situation was determined to exist related to accident hazards.<br><br>1.The facility failed to ensure hot liquids were served at a safe temperature.<br><br>A resident assessment, dated 04/24/25, showed Resident #38 had severely impaired cognition and required supervision for eating.<br><br>A May 2025 active physician's order summary showed Resident #38 had diagnoses which included dementia, delusional disorders, and blister unspecified thigh.<br><br>An untitled document, dated 05/08/25, showed Resident #38 sustained a superficial burn injury on their upper left and right thigh after coming in contact with hot coffee.<br><br>2. The facility failed to ensure chemicals were properly secured when Resident #52 ingested Pine-Sol that<br><br>was kept in a Styrofoam cup.<br><br>A care plan, dated 03/07/25, showed Resident #52 had diagnoses which included intellectual disability, psychotic disorder, cerebral palsy, acute respiratory failure, and pneumonitis due to aspiration of vomit.<br><br>A quarterly resident assessment, dated 03/12/25, showed Resident #52 had severe cognitive impairment and required supervision for eating.<br><br>An incident report, dated 05/15/25, showed Resident #52 ingested less than half a cup of Pine-Sol when a housekeeper put it in a Styrofoam cup and placed it on the cart.<br><br>On 05/21/25 at 5:01 p.m., the OSDH was notified and verified the existence of the IJ situation.<br><br>On 05/21/25 at 5:10 p.m., the administrator was informed of the existence of an IJ situation and was provided the IJ template.<br><br>On 05/22/25 at 1:17 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part,<br><br>(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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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Broadway Care and Rehab<br><br>5/21/2025 [at] 5:10 p.m.<br><br>Nature of IJ: Resident sustained burns from spilling hot coffee on [their] legs on 5-8-25.<br><br>1. Immediate Corrective Action Taken for Affected Resident(s):<br><br>Immediate Actions to Prevent Further Harm:<br><br>Facility immediately provided first aide and orders to ensure proper care.<br><br>Facility provided ice coffee and cup with a lid for safety of the resident, and provided a lap blanket for an additional layer of protection.<br><br>1. Evidence of IJ Removal<br><br>.No further incidents involving hot beverage burns have occurred since corrective actions were implemented on 5-8-25.<br><br>.100% staff education on hot liquids, see attached education on 5/22/2025, will be completed by 2:30 p.m. for all staff.<br><br>.The facility educated all kitchen staff on 5/22/2025 to ensure temperature is 140 degrees or below when placed in carafes for serving, completed by 2:30 p.m.<br><br>.The facility created a daily coffee audit on 5/22/2025 with the updated temperature in place, kitchen staff all educated on new coffee temperature process by 2:30 p.m.<br><br>.Broadway did 100% hot liquid assessments on all current residents on 5-22-25 to be completed by 2:30 p.m.<br><br>.The facility educated all alert and oriented residents with a BIMS of 8 or greater regarding hot liquids and best practices when using hot liquids on 5-22-25 by 2:30 p.m.<br><br>.Care plans and Kardex updated to reflect all residents requiring additional safety interventions with hot liquids on 5-22-25 by 2:30 p.m.<br><br>.The facility added a hot liquids assessment to the admission checklist for new admissions<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | and/or readmissions, changes in condition on 5-22-2025 by 1:00 p.m.<br><br>.The facility added the education and an example of a hot liquids assessment to place in<br><br>new hire orientation packet on 5-22-2025 by 1:00 p.m.<br><br>.Staff who are not currently at work or unable to be contacted via telephone will be<br><br>educated prior to returning to work.<br><br>On 05/22/25 at 3:23 p.m., after interviews with facility staff, review of in-services, resident assessments, care plans, and audits related to hot liquids the immediacy was lifted, effective 05/22/25 at 2:30 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm.<br><br>Based on observation, record review, and interview, the facility failed to ensure:<br><br>a. coffee was served at a safe temperature for 1 (#38); and<br><br>b. chemicals were properly secured for 1 (#52) of 3 sampled residents reviewed for accident hazards.<br><br>The administrator identified 75 residents resided in the facility and 73 residents received services from the kitchen.<br><br>Findings:<br><br>1. On 05/21/25 at 11:29 a.m., Resident #38 was observed to have a brown foam dressings on their right and left inner thighs.<br><br>On 05/21/25 at 11:36 a.m., Resident #38 was observed feeding themselves lunch. They were observed to pick up their cup of purple liquid and was shaking while bringing the cup up to their mouth.<br><br>On 05/21/25 at 11:50 a.m., Resident #38 was observed to receive a cup of coffee and took a sip of the coffee and placed the cup back on the table.<br><br>On 05/21/25 at 11:54 a.m., a cup of coffee was dispensed from an insulated portable coffee dispenser on B hall. The temperature of the cup of coffee was 155.9 degrees F. The cup of coffee was sampled. Steam was observed coming off the coffee in the cup. The coffee was very hot and there was an instant sting on the surveyor's lip.<br><br>On 05/21/25 at 12:05 p.m., Resident #38's wound care was observed. Wounds were observed to the left and right inner thighs. Both wounds were observed covered with yellow slough.<br><br>On 05/21/25 at 12:17 p.m., coffee was obtained from an insulated portable coffee dispenser on A hall. The temperature of the coffee was 150.6 degrees F. The cup of coffee was sampled. Steam was observed coming off the coffee in the cup. The coffee was very hot and there was an instant sting on the surveyor's lip.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 05/21/25 at 12:36 p.m., dietary cook #1 dispensed coffee from the coffee machine in the kitchen. They were was observed to take a temperature of the coffee. The thermometer was observed to read 166 degrees F.<br><br>Resident #38's Annual Assessment, dated 04/24/25, showed Resident #38's BIMS score was 3 which indicated Resident #38's cognition was severely impaired. The assessment showed Resident #38 required supervision/touch assistance with eating tasks.<br><br>A May 2025 active physician's order summary showed Resident #38 had diagnoses which included dementia, lack of coordination, other symptoms and signs involving cognitive functions and awareness, and blister to unspecified thighs<br><br>A Nurse's Note, dated 05/08/25, read in part, CNA [certified nursing assistant] reported to this nurse that resident spilled hot coffee in [their] lap in the dining room. Evaluated skin, pinkness noted to front of bilateral thighs. This nurse asked resident what happened, resident stated, 'I just dropped my cup.' Evaluated resident's thighs, pinkness noted, applied cool cloths to both thighs.Reevaluated and noted pinkness went to redness in small area of groin on both thighs. Notified [name withheld] new order to apply Silvadene [used to treat or prevent serious infection on areas of skin with second-or third-degree burns] to redness until resolved. Applied Silvadene at this time.<br><br>An untitled document, dated 05/08/25, showed Resident #38 sustained a superficial burn injury on their upper left and right thigh after coming into contact with hot coffee. The document showed first aid was applied to the affected area, resident monitored, incident reported to registered nurse and facility leadership, family and physician notified, incident documented, and care plan was updated with new interventions. The document showed new interventions were a lid was to be placed on Resident #38's beverage and ice was to be added to cool prior to serving the beverage.<br><br>The document showed the Root Cause Analysis contributing factors were coffee served at a hot temperature and inadequate staff awareness of burn risk protocols. The document showed all direct care staff were in-serviced on proper temperatures for serving in memory care and those requiring lids for coffee. The document showed coffee temperatures 120 degrees or below were in place. The document showed audit initiated immediately post-incident included all hot beverage delivery processes across the facility, a standardized checklist included temperature check before serving. The document showed compliance rate with checklist completed 100% of audit on 05/08/25. There was no documentation of all staff in-serviced or checklist of temperature checks.<br><br>An undated resident list showed 18 residents resided on B hall. The list showed check marks by 16 residents' names. Resident #38's name was circled and lid and ice cubes were wrote next to their name.<br><br>Resident #38's Order Summary Report, dated 05/09/25, showed:<br><br>a. wound care physician may consult related to non-pressure ulcers to bilateral thighs, and<br><br>b. Silvadene to left inner thigh and right inner thigh every day shift and as needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A Direct Care Staff in-service for Hot Liquids, dated 05/09/25, read in part, Please make sure you are putting a few ice cubes in [Resident #38]'s coffee to cool it down and that [they are] utilizing [their] new cup with the lid on it before serving it to [them]. Please sign signature page to acknowledge. Thank you, [Administrator]. There were 13 staff signatures with the in-service. The staff members were from different departments. The dates ranged from 05/09/25 to 05/20/25. There was no documentation all staff had been in-serviced.<br><br>Resident #38's care plan, revised 05/14/25, showed Resident #38 had a skin injury by sustaining a burn to their lap from spilling hot coffee on 05/08/25. The care plan showed interventions included Resident #38 used a cup with a lid to prevent spillage and staff were to place ice cubes to hot drinks.<br><br>A Wound Evaluation and Management Summary, dated 05/14/25, showed Resident #38 had wounds to their left and right thighs. The summary showed burn wound of the right thigh full thickness. The summary showed burn wound of the left thigh full thickness.<br><br>On 05/20/25 at 1:05 p.m., a family member stated Resident #38 had been burned by coffee. They stated they did not think the staff were giving Resident #38 coffee anymore. The family member stated they told the staff to give cold coffee. They stated they told the staff they should not be giving residents hot coffee when the residents were shaky. The family member stated they told the staff the coffee should not be hot enough to cause blisters.<br><br>On 05/21/25 at 9:51 a.m., an anonymous resident group was asked how about the coffee temperature. They stated it had been hot since the staff had used the new dispensers. They were asked if they were able to drink the coffee right when they were served it. They stated it would burn their mouth.<br><br>On 05/21/25 at 12:02 p.m., the wound care doctor stated they did not diagnosis the degree of the burn because they did not see it initially. They stated they saw it approximately a week later. The wound doctor stated they would observe the wounds and would see what they were.<br><br>On 05/21/25 at 12:07 p.m., the wound doctor stated they thought both wounds were 3rd degree, but the wounds were still pretty covered. They stated they planned to debride the wounds next week and thought they would probably observe muscle after debridement.<br><br>On 05/21/25 at 12:24 p.m., CMA #2 stated Resident #38 spilled coffee on themselves. They stated Resident #38 used a special cup with a lid and handle now. CMA #2 stated staff added a few ice cubes to the coffee. They stated they would feel the outside of the cup to see how hot it was prior to giving it to the residents.<br><br>On 05/21/25 at 12:27 p.m., CMA #2 was asked how staff ensured the coffee was a safe temperature for residents. They stated they knew what residents had shaky hands. CMA #2 stated they knew who would wait for the coffee to cool down. They stated the residents knew not to spill it on themselves. CMA #2 was asked what if the residents accidentally spilled the coffee on themselves. They stated, I don't have an answer for that.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 05/21/25 at 12:29 p.m., the DON stated Resident #38 spilled coffee on themselves. They stated staff completed a skin assessment, applied cool compresses, notified the physician and received an order for Silvadine. The DON stated Resident #38 used a special cup and they added ice cubes to their coffee.<br><br>On 05/21/25 at 12:30 p.m., the DON was asked how burns from hot liquids were prevented to other residents. They stated dietary checked the temperature in the dining room before the drinks went out to the halls, prior to serving each meal.<br><br>On 05/21/25 at 12:32 p.m., dietary aide #1 was asked if staff checked the temperature of the coffee before serving. They stated, I don't know.<br><br>On 05/21/25 at 12:34 p.m., the dietary manager was asked what the procedure was for taking temperatures of the coffee. They stated they did not know and would need to ask dietary cook #1.<br><br>On 05/21/25 at 12:35 p.m., dietary cook #1 was asked if staff took temperatures of the coffee prior to serving. They stated, Not really. They want it to be 155-175 for the halls.<br><br>On 05/21/25 at 2:02 p.m., the administrator stated Resident #38 spilled coffee on their lap. They stated the resident's skin was pink in color and the next day it had blisters. The administrator stated the incident happened on B hall during breakfast time. They stated staff obtained an order for Silvadene on the same day.<br><br>On 05/21/25 at 2:03 p.m., the administrator and regional director were asked what had been implemented to prevent the incident from recurring. The administrator stated the resident used a cup with a lid and staff cooled the coffee before giving it to the resident. They stated they educated the staff and completed an ad hoc QAPI. The regional director stated they completed an audit on other residents.<br><br>On 05/21/25 at 2:05 p.m., the administrator was asked what was a safe temperature for coffee. They stated coffee needed to be brewed to 160 degrees for safe consumption and then cooled to 120 degrees or below.<br><br>On 05/21/25 at 2:06 p.m., the administrator was asked what the temperature of coffee was currently being served to the residents. They stated 160-165 degrees out of the pot, and then cool it to 120 degrees. The administrator was asked how staff knew what the temperature of the coffee was. They stated, Kitchen would have to get them a thermometer. They were asked if that had been done. They stated, Should be.<br><br>On 05/21/25 at 2:07 p.m., the administrator was asked to provide the policy and any documentation related to the incident with Resident #38.<br><br>On 05/21/25 at 2:36 p.m., the administrator stated they did not have a policy. They were asked what residents had been assessed to be at risk. They stated all the residents on B hall because that was where the incident occurred.<br><br>2. On 05/21/25 at 11:18 a.m., Resident #52 was observed on B hall propelling themselves in a wheelchair in the hallway.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A care plan, dated 03/07/25, showed Resident #52 had diagnoses which included acute/chronic respiratory failure with hypoxia and psychotic disorder. The care plan showed Resident #52 had impaired cognitive function.<br><br>A quarterly resident assessment, dated 03/12/25, showed Resident #52 sometimes understands, rarely/never made decisions, and required supervision for eating.<br><br>A Nurse's Note, dated 05/15/25 at 9:24 a.m., read in part, Text: Housekeeper called this nurse into resident's room. Housekeeper stated this resident had consumed a small amount of Pine Sol in a small Styrofoam cup. Resident was sitting in [their] wheelchair in [their] room. [Resident #52] appeared ok. Asked resident what happened, [they] stated, I want coffee. Notified Poison Control Center. Poison Control Center stated to monitor resident and watch for excessive vomiting and diarrhea and should be able to treat [them] in facility. Shortly after, resident began to dry heave, then tried to vomit but kept swallowing it when it reached [their] throat/mouth.Resident then projectile vomited x1., [DON] went to resident's room and assessed resident. Staff came to door at end of unit to let this nurse know that resident had vomited and that [DON], stated to get paperwork together because [Resident #52] is going to hospital because [Resident #52] was having trouble breathing. O2 Sat at this time 77%RA [room air]. EMS notified. Oxygen applied, O2 sat [saturation] 85%. Resident began to have trouble staying alert, awake, and became lethargic off and on, staff kept trying to keep resident stimulated. EMS arrived x2 attendants. Resident O2 sat 87% with EMS oxygen on. EMS transferred resident to gurney and transported resident to [local hospital].<br><br>A Nurses Note, dated 05/15/25 at 11:22 a.m., read in part, Note Text: Spoke with Hospital nurse, resident has been admitted with Dx [diagnoses]: Respiratory Failure with Hypoxia and Aspiration Pneumonitis.<br><br>An all-staff in-service, dated 05/15/25, showed all housekeeping carts were to remain locked when unattended and all chemicals were to be kept out of the reach of residents.<br><br>An ad-hoc QAPI meeting report, dated 05/15/25, showed a problem of chemical ingestion. The report showed staff had been in-serviced and audits were conducted to ensure residents did not have access to chemicals. The report showed audit tools were used to monitor chemical storage.<br><br>A hospital note, dated 05/19/25, showed Resident #52 had been admitted to the hospital on [DATE] with diagnoses of acute respiratory failure secondary to possible aspiration pneumonia.<br><br>An admit/readmit note, dated 05/20/25 at 6:08 p.m., read in part, Note Text: resident to arrive back from [hospital] .residents' vitals are blood pressure 149/79, pulse of 84, temp [temperature] of 98.7, spo2 [peripheral oxygen saturation] of 96% on rm [room] air, and rr [respiratory rate] 17. resident alert to self. perrla [pupils equal, round, reactive to light and accommodation]. resident respirations are regular and unlabored. lung sounds arecta [are cta] [clear to auscultation]. no shortness of breath noted.<br><br>On 05/21/25 at 2:10 p.m., CNA #4 was asked how they ensured residents did not have access to chemicals. They stated by making sure everything was put up and locked up in the supply closet. CNA #4 was asked how they were aware of which chemical was being used. They stated the chemicals were labeled.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 05/21/25 at 2:13 p.m., LPN #3 was asked how they ensured residents did not have access to chemicals. They stated chemicals were supposed to be put up. LPN #3 stated when they did rounds, they checked to see if any chemicals were in resident rooms and made sure the carts were locked. They stated the staff met every shift to remind all staff to keep chemicals put up. LPN #3 stated chemicals should be in labeled containers.<br><br>On 05/20/25 at 9:56 a.m., housekeeper #1 was asked what the policy was for storing chemicals. They stated chemicals were to be put up, locked up, labeled, and carts locked when unattended.<br><br>On 05/21/25 at 2:58 p.m., the administrator was asked how staff ensured chemicals were not accessible to residents. They stated per their most recent chemical audits to check to see that housekeeping carts were locked, and nothing was in the reach of residents. They stated they checked the entire building three times daily for one week, then daily for one week, and then weekly. The administrator stated they put the chemical education in with the new hire packet. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interview, the facility failed to ensure proper PPE was used for 1 (#24) of 3 sampled residents observed for EBP.<br><br>The administrator identified 75 residents resided in the facility.<br><br>Findings:<br><br>On 05/29/25 at 8:39 a.m., the door frame to Resident #24's room was observed to have EBP signage and a tube feeding was observed hanging on a pole next to the resident's bed.<br><br>On 05/29/25 at 8:57 a.m., LPN #1 entered Resident #24's room, closed the door, turned off the tube feeding, and checked placement with a stethoscope and syringe. LPN #1 had on gloves, but did apply a gown prior to accessing the resident's feeding tube.<br><br>On 05/29/25 at 9:00 a.m., LPN #1 exited Resident #24's room to get water from a cart, returned to the resident's room, applied gloves, but still no gown was applied. PPE was observed inside the resident's room, on the back of the door, which included yellow gowns, gloves, and masks.<br><br>A policy titled Enhanced Barrier Precautions, dated 05/15/24, read in part, The facility may expand the use of PPE [and] refer to the use of gown [and] gloves during high-contact resident care activities that provides the opportunities for transfer of MDROs [multidrug-resistant organism] to hands/clothing. Examples of High-Contact Resident Care Activities requiring Gown [and] Glove Use for EBP .Device Care .Enteral Tube.<br><br>On 05/29/25 at 9:08 a.m., LPN #1 stated Resident #24 was on EBP for a tracheostomy and catheter. LPN #1 was asked about the feeding tube. They stated, Oh, yes.<br><br>On 05/29/25 at 9:09 a.m., LPN #1 stated the policy and procedure for EBP was to wear a yellow gown and gloves. LPN #1 stated they did not apply the required PPE.<br><br>On 05/29/25 at 9:10 a.m., the DON stated the requirements for EBP was to wear gloves, a gown, and a mask. The DON stated they had given all staff badges with the EBP information on it and had completed in-services with all the staff. |