STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375146	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to follow physician orders for 1 (#4) of 3 sampled residents reviewed for physician orders. The administrator identified 83 residents resided in the facility. Findings:A physician order, dated 04/21/25, showed the following medications were to be held starting 04/21/25:aspirin EC 9enteric coated) delayed release 81 mg (an antiplatelet medication used to prevent blood clots) for a procedure scheduled on 04/24/25.Plavix oral tablet 75 milligrams (antiplatelet medication used to prevent blood clots). A physician order, dated 04/24/25, showed Plavix)an anti-platelet) oral tablet was to be held on 04/26/25 for pacemaker placement. A review of the discontinued medications for Resident #4 showed these medications were not discontinued or held as ordered. A quarterly clinical assessment, dated 06/25/25, showed Resident #4 had diagnoses which included metabolic encephalopathy and cerebral ischemia. The assessment showed Resident #4 had a BIMS score of 6 which indicated severe cognitive impairment for decision making. On 07/30/25 at 2:48 p.m. the DON reported Resident #4 had two scheduled procedures to place a pacemaker and because a medication, ordered to be held prior to the procedure, was not withheld for the appropriate length of time, the resident was not able to have the pacemaker placed. The procedures were scheduled for 04/24/25 and 04/25/25. Resident #4 had the pacemaker placed on 05/08/25. The DON reported they were not informed of the first missed procedure, but were notified after the second missed procedure. The DON reported education was provided to all staff who provided medications to residents, and a system was put into place to monitor for resident procedures to ensure this situation did not reoccur. The DON reported the importance of following physician orders was addressed in the quality assurance committee and also at their weekly stand-up meeting. The DON reported the monitoring had begun on 05/01/25 and would continue indefinitely. On 07/30/25 at 4:09 p.m. the administrator provided documentation of:QAPI meeting held on 6/17/25 that addressed following physician ordersEducation dated 05/12/25 for medication aides and nurses that addressed following physician orders. Monitoring documentation for scheduled surgeries that document physician orders reviewed and entered correctly. On 07/30/25, interviews were conducted with LPN #1, CMA #1 and CMA #2. All reported education had been received and demonstrated their knowledge of following physician orders and policy and procedures in place for when residents have scheduled procedures.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure that 1 (#1) of 3 residents reviewed for elopement received adequate supervision to prevent elopement. The Administrator reported a census of 83. Findings:A facility incident report, dated 7/22/23, showed Resident #1 eloped from the locked unit and was returned to the facility by local law enforcement. A tour of the facility was conducted on 07/22/23 to observe the corrective changes made in the window mechanisms. A review of the facility's investigation did not indicate how far the resident went after leaving the facility or the exact time frame the resident had left the facility. Resident records were reviewed for updated elopement status. Maintenance logs were reviewed for daily checks on windows in the locked unit and weekly checks on the windows in the rest of the building.A quarterly assessment, dated 07/14/25, for Resident #1 showed a diagnosis of unspecified dementia and BIMS score of 3 which indicated severe cognitive impairment.On 07/23/25 at 1:53 p.m., the administrator reported they were notified around 6:00 a.m. by the DON Resident #1 could not be located. They were told the facility was being searched and the police had been notified. The administrator reported the resident was returned to the facility at 6:30. The resident reported they had left the facility through a window. The administrator stated they took immediate actions on 07/22/25 to ensure the safety of all residents, and provided documentation of the following:A census audit was conducted on all residents to ensure they were in the building. All windows in the facility were checked to ensure they were safe. All residents were reassessed for elopement.Maintenance replaced all the screws that enabled windows to be partially opened. These screws were put in place on the outside of the window to ensure they could not be tampered with from the inside of the facility.Weekly audits on windows were increased to every day for the locked unit. All staff were educated on elopement risks and how to identify elopement behavior. Resident #1 was assessed for any physical injury and checks were conducted every 15 minutes. On 07/23/25 at 2:35 p.m., Resident #1 stated they left because they wanted to go to (name-withheld city) to get to the bank. Resident #1 did not recall how they got out of the building or how far away from the facility they were when found by law enforcement.On 07/23/25 at 3:00 p.m., interviews with 5 staff from different departments were conducted regarding knowledge of elopement risks and behaviors, and to confirm re-education by the facility.