STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375491	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROADWAY LIVING CENTER	301 BROADWAY LEXINGTON, OK 73051

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation and interview, it was determined the facility failed to ensure one (#13) of two sampled residents were treated with dignity during dining for two of two dining observations. The facility identified nine residents who required assistance with eating. Findings: On 03/03/20 at 11:00 a.m., resident #13 was observed to be in the dining room at the assisted table. At 11:29 a.m., the resident was served her meal and was assisted by ACMA #3. At 11:50 a.m., the ACMA asked for a plastic spoon from dietary staff. ACMA #3 used the plastic spoon to feed the resident her dessert. At 12:02 p.m., the resident finished her dessert. The ACMA was asked why this resident was fed with a plastic spoon, She stated she used the plastic spoon because her metal spoon had food stuck on it from her lunch. She was asked if a plastic spoon was used due to availability of metal silverware or due to a preference. The ACMA stated it was just her preference to use a plastic spoon. On 03/04/20 at 10:50 a.m., resident #13 was assisted to the dining room for the noon meal. At 11:15 a.m., staff were observed to be passing fluids to the residents in the dining room. This resident was not offered any fluids. At 11:36 a.m., dietary staff had a glass of water and asked her if she wanted a drink. The resident shook head no At 11:47 a.m., CNA #3 sat down in front of the resident, put the cup to her mouth and asked if she wanted a drink of water. The resident immediately drank from the cup. The resident waited 57 minutes sitting at the dining room table for staff to sit and offer fluids. On 03/05/20 at 11:11 a.m., the DON and the corporate RN were asked if it was okay for residents to be fed with plastic ware at the preference of the staff. The DON stated no, not at the preference of the staff. The corporate RN stated no, never. Not at the preference of the staff, no. They were asked how long a resident should wait to be provided a drink while waiting on their meal. The corporate nurse stated approoximately 15 - 20 minutes.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure one (#64) of one sampled residents was provided a means to ambulate in the facility without being confined to a wheelchair. The facility identified 25 residents who required assistance with mobility and 87 residents who resided in the facility. Findings: Resident #64 had [DIAGNOSES REDACTED]. An annual assessment, dated 01/23/20, documented the resident's cognition was severely impaired and was independent with the use of a wheelchair for mobility. A care plan for ADLs, dated 02/11/20, documented the resident was primarily independent with her ADL tasks. She was able to self transfer, dress and toilet herself. She utilized a wheelchair for mobility and at times would stand up and push the backwards facing chair, and was unable to be redirected. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction. The clinical record documented the resident was receiving weekly restorative care and continued to work with ambulatory lower extremity exercises, both active and passive. On all days of the survey, the resident was observed to stand up, face her wheelchair and push it down the hall. When staff observed the resident, they stopped her and told her to sit in the wheelchair. The resident complied and would sit down. On 03/05/20 at 9:43 a.m., CNA #5 was asked if the resident could ambulate by herself. She stated the resident could walk behind her wheelchair and she transferred herself. She was asked if the resident had any falls. She stated she was not aware of any. The CNA was asked if she observed the resident ambulate safely. She stated yes. She was asked why the resident was encouraged to use a wheelchair instead of another means. She stated it was because it was in her care plan to use a wheelchair and they were to direct her to sit down if they observed her up. She stated it was up to the DON and ADON as they were the ones who made the care plan. At 11:19 a.m., the DON was asked if the resident was capable of ambulating. She stated yes, she could walk behind the wheelchair. She was informed of the observations of staff telling her she needed to sit in her wheelchair when they observed her up walking behind it. She stated yes, it did take away from her independence. They would look at that concern.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure one (#5) of one sampled residents were provided timely incontinent care. Findings: A quarterly assessment, dated 11/14/19, documented the resident's cognition was severely impaired, required extensive assistance of one person with toilet use and was incontinent of bowel and bladder. A care plan, dated 05/30/19, documented the resident had bladder incontinence related to [MEDICAL CONDITION] and impaired mobility. Interventions documented for staff to check and change the resident every two hours and as needed for incontinence. On 03/04/20 at 8:31 a.m., the resident was resting in bed with her eyes closed. She was in a supine position with the head of her bed at approximately 45 degrees. At 9:31 a.m., staff entered the room and provided incontinent care to the resident's roommate. At 10:00 a.m., CNA #2 went into resident's room. She opened the blinds and turned off the light. No incontinent care or repositioning was provided. At 10:35 a.m., staff entered the room and provided incontinent care to the resident's roommate. At 11:58 a.m., CNA #6 stood at door watching the resident for 3 minutes. At 12:46 p.m., ACMA #1 and #2 were observed to provide incontinent care to the resident's roommate. The resident was observed from 8:31 a.m. until 1:02 p.m., to be in the same position and was not provided incontinent care. At 1:02 p.m., ACMA #1 and #2 went into the resident's room to assist with incontinent care. The brief was removed and was observed to have dried urine stains and smears of dried feces. The bed pad and sheets were saturated with urine. The resident had not been repositioned or provided incontinent care for four hours and thirty-one minutes. ACMA #1 was asked what the pad and sheets were saturated with. She stated probably urine from not being changed. ACMA #2 stated she did not feel like the every two hour bed check had occurred like it was supposed to. ACMA #1 and #2 were asked how often a dependent resident was to be repositioned and provided incontinent care. They stated at least every 2 hours. ACMA #2 also stated sometimes more often than every 2 hours. On 03/05/20 at 11:11 a.m., the DON and the corporate RN were asked how often a resident should be repositioned and provided incontinent care. The DON stated at least every 2 hours and as needed. The corporate RN nodded her head up in down in agreement.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure fluids and/or ice were

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) provided for two (#13 and #55) of three sampled residents who were reviewed for hydration. The facility identified 87 residents who resided in the facility. Findings: 1. Resident #13 had [DIAGNOSES REDACTED]. A care plan, dated 09/22/19, documented the resident was unaware of her needs and wants. Interventions documented staff were to anticipate for her. A quarterly assessment, dated 11/22/19, documented the resident's cognition was severely impaired and she required limited assistance of one staff member for eating. The current physician's orders [REDACTED]. On 03/04/20 from 8:28 a.m. through 11:47 a.m., there was no water or cup observed in the resident's room for hydration. At 9:11 a.m., CNA #2 was observed to pass ice and water to residents on the East hall except for resident #13. At 9:28 a.m., the AD was observed to open a mouth swab and clean the resident's mouth. The resident clamped her mouth onto the swab as soon as it was placed in her mouth and began sucking on it. The AD did not offer the resident any fluids to drink. At 10:00 a.m., CNA #2 entered the resident's room, went to the window and opened up the blinds and turned the light off. She was not observed to offer the resident any fluids to drink. At 10:35 a.m., CNA #2 and #3 transferred the resident from her bed to the geri chair. At 10:50 a.m., the resident was assisted to the dining room for the noon meal. The CNAs were not observed to offer the resident any fluids. At 11:15 a.m., staff were observed to be passing fluids to the residents in the dining room. This resident was not offered any fluids. At 11:36 a.m., dietary staff had a cup of water and asked her if she wanted a drink. The resident shook her head no. At 11:47 a.m., CNA #3 sat down in front of the resident, put the cup to her mouth and asked if she wanted a drink of water. The resident immediately drank from the cup. The resident was not provided a drink of water except for a small amount with the medication pass provided in the dining room. At 3:29 p.m., ACMA #1 and the corporate RN were asked how often residents should be offered fluids. ACMA #1 stated every hour at least. The corporate RN stated fluids should be offered during rounding or every time staff entered a resident's room. At 3:37 p.m., CNA #4 was asked how often fluids were offered to the residents. She stated rounds were made with the hydration cart every morning, afternoon, evening and every two hours in between. She was asked when dependant residents were offered fluids. She stated they always provided them their fluids. The CNA was observed to pass fluids on the East hall except for resident #13. At 3:49 p.m., CNA #4 was asked when residents who required thickened liquids were offered fluids. She stated either herself or another staff member passed thickened liquids every two hours. She was asked if they had been passed. She stated the thickened drinks are in the kitchen. 2. Resident #55 had a [DIAGNOSES REDACTED]. A quarterly assessment, dated 01/17/20 documented the resident's cognition was moderately impaired, required limited assistance with one staff member for eating The current physician's orders [REDACTED]. On 03/02/20 at 2:59 p.m., there was no water or cup observed in the resident's room for hydration. On 03/03/20 from 9:32 a.m. through 11:10 a.m., there was no water or cup observed in the resident's room for hydration. On 03/04/20 from 8:49 a.m. through 10:44 a.m., there was no water or cup observed in the resident's room for hydration. At 3:23 p.m. the resident was asked if he received fluids in his room between breakfast and lunch. He stated no. He was asked of any staff offered any fluids. He stated no. He was asked if he would have like to had been offered a drink. He stated yes.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on record review and interview, it was determined the facility failed to establish and maintain a comprehensive infection prevention and control tracking and trending program. The facility identified 87 residents who resided in the facility. Findings: On 03/05/20 at 10:02 a.m., the infection prevention tracking documentation was reviewed. There were 67 skin/soft tissue infections, 41 urinary tract infections and 31 respiratory infections identified in the facility in 2019. There was no documentation provided for the current year. At 10:50 a.m., the DON was asked about the infection control program. She stated they had not documented infection trends, researched the rationale for the infections, or enacted appropriate interventions to help prevent the development and transmission of infections within the facility.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined the facility failed to ensure one (#40) of one sampled residents call light system was accessible and functioning. Findings: Resident #40 had [DIAGNOSES REDACTED]. A quarterly assessment, dated 01/06/20, documented the resident's cognition was intact, ambulated independently and had one fall with a major injury. A care plan, dated 02/13/20, documented the resident was at risk for falls due to routine use of [MEDICAL CONDITION] medications and had a history of [REDACTED]. Interventions documented staff were to ensure the call system pull string was within reach, encourage the resident to use the call system for assistance as needed and to provide prompt response to all requests for assistance. On 03/03/20 at 9:45 a.m., the resident's call light string was observed to be caught in two drawers of two separate dressers and was not accessible to the resident. At 9:57 a.m., the resident was asked if she had a call light. She stated she was not aware she had a call light. At 10:04 a.m., CNA #1 was asked where the call light cord was located. She stated the call light string was stuck in between two separate dressers and the wall and was not accessible to the resident. She freed the call light string from the drawers and furniture. The CNA pulled the call light string from waist level, from bed level, and one foot directly from the wall and the call system would not activate. She stated the call system was not in working order. On 03/04/20 at 10:42 a.m., LPN #1 stated CNA #1 had reported the call system was not functioning and was not accessible to the resident. The LPN stated she reported this to the maintenance director. At 11:09 a.m., the maintenance director stated he had repaired the call system. He stated he added string to the switch to ensure accessibility for the resident and installed an I-hook in the cement wall to ensure the call system would be activated when the string was pulled.