

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Broadway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 West Broadway Glendale, CA 91204	

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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219</p> <p>Based on interview and record review, the facility failed to treat one of four sampled residents (Resident 4) with respect and dignity by failing to ensure to maintain Resident 4 ' s bodily privacy during an inspection of her G-Tube (a tube inserted through the belly that brings nutrition directly to the stomach) by LVN 1, which resulted in the resident's gastrointestinal tube being exposed in the resident ' s common Dining Area.</p> <p>This deficient practice had the potential to negatively impact residents leading to shame, depression, and embarrassment, diminishing the importance of emotional and psychological health.</p> <p>Findings:</p> <p>1. A review of Resident 4 ' s Admission Record indicated the resident was admitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing or not able to swallow) and gastro-esophageal reflux (a condition which the stomach contents move up into the throat) disease.</p> <p>A review of Resident ' 4 History and Physical dated 5/21/24, indicated the resident dis not have the capacity to understand and make decisions but is able to make decisions for activities of daily living.</p> <p>A review of Resident 4 ' s Minimum data Set (MDS - a comprehensive assessment used as a care- planning tool) dated 5/28/2024, indicated resident requires maximum assistance for all self-care tasks such as, oral hygiene, toileting, showering, and dressing.</p> <p>A review of Resident 4 ' s Care Plan initiated on 5/28/2024 and revised on 7/5/2024 indicated Enteral feeding through g-tube interventions are to maintain resident ' privacy and respect their rights.</p> <p>2. A review of Resident 1 ' s Admission record indicated the resident was admitted on [DATE], with diagnoses that included obesity (having too much body fat) and gout (pain and swelling of the joints).</p> <p>A review of Resident 1 ' s History and Physical dated 9/25/23, indicated the resident has the capacity to understand and make decisions.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Psychiatric Progress Note dated 4/26/2024 indicated Resident has a BIM (Brief interview for mental status) score of 15.</p> <p>A review of Resident 1's MDS dated [DATE], indicated resident mental status was intact without deficit in ability to recall.</p> <p>During a telephone interview with Resident 1 on 7/11/2024 at 7:35 am, Resident 1 stated while in the common resident Dining Area RN 1 entered and began to feed Resident 4 through a G-tube. Resident 1 stated she informed RN 1 that feeding Resident 4 via gtube in the main Dining Room was not appropriate and should be done in privacy. Resident 1 stated RN1 wheeled Resident 4 out of room after Resident 1 made a comment about it.</p> <p>During an interview with RN 1 on 7/11/2024 at 10 am, RN 1 stated if a resident has a G-tube the facility practice is to use enhanced PPE when providing care through g-tube and to provide enteral nutrition and medications in the privacy of the resident ' s room. RN 1 stated the purpose of feeding a resident only in their room, is to implement enhanced precautions, provide privacy and to provide respect for the resident. RN 1 stated she did not feed Resident 1 in the Dining Area but was checking the G-Tube to ensure the valve was clamped and not leaking and went on to state that she did not have on enhanced PPE during that time.</p> <p>During an interview with the ADM on 7/11/2024 at 11:24 am, she stated the incident was brought to her attention by the DON who had interviewed RN1 stating she had visualized the G-Tube valve to ensure it was closed in dinning room only exposing the tip of G-Tube. The ADM stated she had spoken with Resident 1 and provided reassurance that what she observed with RN 1 and Resident 1 was taken seriously and have provided in-service to the nurses.</p> <p>During an interview with the DON on 7/11/2024 at 12:41 pm, she stated Resident 1 had come to her and complained that RN1 was feeding Resident 4 through her g-tube in the Dining Room. The DON stated RN 1 denies feeding Resident 4 through the g-tube and was only checking the valve to ensure it was closed.</p> <p>During an interview with Resident 1 on 7/11/2024 at 1 PM, she stated what made her think that Resident 4 was being fed through the gtube was because she saw a plastic round can that had a pour spout, and saw RN 1 was scooping out liquid. Resident 1 stated she was able to visualize the tube of Resident 4 while RN 1 was feeding Resident 4. Resident 1 stated this made her mad that the RN would do this Infront of everyone. Resident 1 stated We should not have to watch this .This resident should have her privacy respected.</p> <p>During an interview with the DON on 7/11/2024 at 2:27 pm, she stated the facility have a responsibility to make sure that every resident is treated with respect, dignity, and privacy.</p> <p>A review of the facility ' s policy and procedure revised on February 2021, titled Dignity indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well- being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy interpretation and intervention include residents are to be treated with dignity and respect at all times. Staff is to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		