STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055670	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Manor Care Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Amended Copy - [DATE] Based on interview and record review the facility failed to assess, monitor for the signs and symptoms of Peripheral Arterial Disease (PAD- also known as peripheral vascular disease [PVD], a circulatory problem where narrowed arteries reduce blood flow to the legs, arms, or other parts of the body, often due to plaque buildup), and follow the general acute care hospital (GACH 1) physician and facility ' s attending physician ' s recommendations for one of three sampled residents (Resident 1), who was recently hospitalized for an acute cerebrovascular accident (CVA - a type of stroke [occurred when blood flow to the brain was interrupted], loss of blood flow to a part of the brain), right internal carotid artery stenosis ([NAME]- a condition that happens when the carotid artery, which is the large artery on either side of the neck, becomes blocked), and PAD, by failing to: Ensure the facility ' s licensed staff and the attending physician, identified and addressed Resident 1 ' s diagnoses of PAD and Atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls. This buildup is called plaque) and include in the resident ' s cumulative diagnoses list (a compilation of all diagnoses a patient has received, including past and present conditions, to provide a comprehensive overview of their medical history) upon readmission to the facility on [DATE], to establish the resident ' s diagnoses while in the facility to maximize the resident ' s treatment benefits and ensure resident outcome and safety. Ensure the facility ' s licensed staff referred Resident 1 for an elective (a procedure that was chosen [elected] by the patient or physician that was advantageous to the patient but was not urgent) bilateral lower extremity (legs) arteriogram (a medical imaging procedure to visualize and assess blood flow in the arteries [blood vessels] and detect blockages to plan for surgical interventions) and endovascular intervention (a surgical procedure used to treat a wide range of vascular conditions including PAD and stenosis [narrowing of a passageway in the body]), in accordance with the GACH 1 Discharge Summary orders made by the GACH 1 Physician on [DATE]. Ensure the facility ' s licensed staff develop a PAD/PVD and Atherosclerosis comprehensive and individualized care plans, in accordance with the facility ' s policy & procedures titled Care Area Assessments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Ensure the facility ' s licensed staff monitor Resident 1 ' s bilateral (both) pedal pulses (palpable pulse wave in the arteries of the foot. It is a clinical sign used to assess the circulation in the lower extremities) as indicated in the resident ' s Physician ' s Order dated [DATE]. The licensed nurses documented monitoring and assessment of Resident 1 ' s left pedal pulses from [DATE] to [DATE] and did not have documentation of monitoring and assessment of Resident 1 ' s right pedal pulses from [DATE] to [DATE]. The order for bilateral pedal pulses monitoring was discontinued without a reason on [DATE]. As a result of these deficient practices Resident 1 did not receive the care, services, and interventions to ensure the resident ' s PAD/PVD were addressed during the resident ' s stay in the facility from [DATE] to [DATE]. These deficient practices resulted in a change in Resident 1 ' s condition on [DATE], when Resident 1 developed altered level of consciousness (ALOC), and fluctuating oxygen saturation (indicated how much oxygen the blood was carrying, [normal ranges from 95% to 100%) of 86 to 90%. Resident 1 was transferred to GACH 2 via 911 emergency services on [DATE]. Resident 1 ' s GACH 2 physician notes indicated Resident 1 had a suspected right lower extremity superficial femoral artery occlusion (refers to a partial or complete blockage of the femoral artery [a large blood vessel located in the upper thigh], which can lead to reduced blood flow and oxygen supply to the lower leg and foot). Resident 1 died at GACH 2, two days after the GACH 2 admission, on [DATE], with diagnoses that included but not limited to cellulitis of the leg (a bacterial infection of the skin and the tissues beneath the skin), right lower extremity gangrenous (when lack of blood flow causes tissues in the body to die) changes, PAD and septic shock (a subset of sepsis [a serious condition in which the body responds improperly to an infection] in which particularly profound circulatory (the system that contains the heart and the blood vessels and moves blood throughout the body) and metabolic abnormalities [disruptions in the body's chemical processes that convert food into energy and building blocks] substantially increase death). Findings: During a review of Resident 1 ' s GACH 1 record, the resident ' s Duplex Ultrasound ([US] a test to see how blood moves/flows through the arteries and vein) dated [DATE] was reviewed. The US indicated that Resident 1 ' s Right Lower Extremity Arterial (a blood vessel that carried blood from the heart to the tissues and organs in the body) US indicated 50 to 75% stenosis in the mid superficial (on the surface) femoral artery (the main blood vessel that delivered oxygen-rich blood from the heart to your lower body, specifically the thigh and leg), 30 to 49% stenosis in the right external iliac artery (a major blood vessel that carried oxygenated blood from the pelvis [bone that connects spine to the legs] to the legs) . During a review of Resident 1 ' s GACH 1 Left Lower Extremity Arterial Duplex (sound waves used to create images of blood vessels and assess blood flow) dated [DATE], the Ultrasound indicated Severe diffuse calcific (buildup of calcium deposits that could lead to hardening of tissues, blood vessels, or organs) atherosclerotic disease identified throughout the left lower extremity with at least moderate stenosis left external iliac (brings blood to the legs) and common femoral arteries with severe stenosis within the proximal (center of the body) and mid superficial (located on or near the surface of the body) femoral artery of at least 50 to 75% narrowing . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s GACH 1 Interventional Radiologist ' s (IR, a medical specialty that used imaging techniques to guide tiny instruments through the body to diagnose and treat diseases) Consultation dated [DATE], the IR Consultation indicated Resident 1 would benefit from an elective bilateral lower extremity arteriogram and endovascular intervention when the resident is stable . During a review of Resident 1 ' s GACH 1 DC Summary dated [DATE], authored by the GACH 1 physician, the DC Summary indicated one of Resident 1 ' s problems included PAD. The DC Summary indicated Resident 1 ' s reason for admission to GACH 1 was Left Upper Extremity and Left Lower Extremity (LLE) numbness and weakness. The DC Summary indicated Resident 1 was deemed stable for discharge back to the facility. The DC Summary included the following problems for Resident 1: 1. Acute CVA 2. Stenosis of right internal carotid artery ([NAME]). 3. PAD - Doppler Ultrasound (used sound waves to visualize and measure blood flow in vessels, arteries, and veins, helping doctors assess blood flow speed and direction, and detect conditions like clots or blockages) showed LLE arterial stenosis and bilateral AT/PT stenosis. IR consulted for further recommendation indicated elective bilateral lower extremity arteriogram and endovascular intervention when resident was stable. Any dual antiplatelet (medications that prevent platelets from clumping together and forming blood clots) therapy would be beneficial for the resident ' s PAD. 4. Diabetes . During a review of Resident 1 ' s Admission Record (AR), the AR indicated the resident was readmitted to the facility on [DATE], with diagnoses that included but not limited to the following: Atherosclerosis of native arteries (a natural, un-altered blood vessel that carried oxygen-rich blood from the heart to the body ' s tissues and organs) of extremities with intermittent claudication (most common symptom of PAD which is pain and numbness in the lower extremities) of bilateral legs. Type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). Cerebral Infarction (or CVA). During a review of a facility record titled Cumulative Diagnosis List dated [DATE], the Cumulative Diagnosis List indicated Resident ' s diagnoses in the facility as provided by the facility ' s Medical Records Director. The Cumulative Diagnosis List indicated Include active diagnoses and conditions that are part of the resident ' s current plan. Enter the date resolved/discontinued when the condition is no longer active. A physician is legally accountable for establishing resident ' s diagnosis. The Cumulative Diagnosis List indicated a column for the physician ' s signature designated next to each of the indicated resident ' s diagnosis. The column for the physician ' s signature indicated a handwritten signature of Physician 1 and was dated [DATE]. The Cumulative Diagnosis List indicated the following handwritten diagnoses for Resident 1: Cerebral Infarction. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Carotid Artery Stenosis (a narrowing of the carotid arteries in the neck). Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing). Diabetes Mellitus Coronary Artery Disease (CAD, a condition where plaque builds up inside the arteries that supply blood to the heart, potentially leading to reduced blood flow and heart problems). Congestive Heart Failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). Anemia (a condition where the body did not have enough healthy red blood cells). Osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). Hypertension (HTN, high blood pressure). Hyperlipidemia (HLD, a condition characterized by abnormally high levels of fats [lipids] like cholesterol in the blood). Major Depressive Disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review Resident 1 ' s Telephone Physician ' s Order dated [DATE], the Physician's Order indicated to monitor Resident 1 ' s bilateral pedal pulses, every day shift. During a review of Resident 1 ' s Treatment Administration Record (TAR) for the month of [DATE], the TAR indicated from [DATE] to [DATE] the resident ' s left pedal pulse was documented and monitored in accordance with the resident ' s Physician ' s Order to monitor bilateral (both) pedal pulses every day shift, instead of both (right and left) pedal pulses. During a review of Resident 1 ' s Facility Active Order Summary Report signed by the physician and dated [DATE], the Summary Report did not include the resident ' s diagnosis of PAD in accordance with the GACH 1 DC summary. During a review of Resident 1 ' s History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated diagnoses including right carotid stenosis and CVA. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS did not indicate Resident 1 had PAD. The MDS indicated the resident had zero number of venous (relating to or involving veins, the blood vessels that carry blood back to the heart, and the blood into those vessels) and arterial (relating to an artery) ulcers present and had no other ulcers (a small open sore [a break in the skin where the skin ' s surface was damaged, missing, or exposing the tissues beneath] or wound generally found in the stomach or on the skin), wounds, and skin problems. During a review of Resident 1 ' s Telephone Physician ' s Order dated [DATE] at 4:18 PM, the Physician ' s Order indicated to discontinue Resident 1 ' s monitor bilateral pedal pulses, everyday shift on [DATE] at 11:17 PM. The Physician ' s Order did not indicate a discontinue reason. During a review of Resident 1 ' s Physician ' s Progress Note dated [DATE], the handwritten Progress Note indicated the attending physician (Physician 1) added a diagnosis of PAD in the resident ' s record. During a review of Resident 1 ' s Physician ' s Progress Note dated [DATE], the handwritten Progress Note continued to indicate the resident had a diagnosis of PAD. During a review of Resident 1 ' s Physician ' s Progress Note dated [DATE], the handwritten Progress Note continued to indicate the resident had a diagnosis of PAD. During a review of Resident 1 ' s TAR for the month of [DATE], the TAR indicated Resident 1 received treatments as ordered, to the right knee open scratch wound and right lateral knee extending to posterior aspect open scratch wound from [DATE] to [DATE]. During a review of Resident 1 ' s Physician ' s Order dated [DATE] at 8:55 AM, the Physician ' s Order indicated treatment - right knee open scratch wound - cleanse with normal saline (NS, a saltwater solution), pat dry, apply medihoney (a wound dressing containing 100% active Leptospermum honey [a type of honey produced by bees that feed on the nectar of the Manuka bush] that helps remove dead tissue, promotes wound healing, and could be used on various types of wounds) and cover with border gauze (a wound dressing with a soft, absorbent gauze pad and an adhesive border) every day (QD) for 14 days every day shift. During a review of Resident 1 ' s Physician ' s Order dated [DATE] at 8:55 AM, the Physician ' s Order indicated treatment - right lateral (to the side of, or away from, the middle of the body) knee extending to posterior (the backside or rear part of the body) aspect open scratch wound - cleansed with NS, pat dry, apply medihoney, cover with Abdominal [ABD] pad (a highly absorbent, sterile dressing used to absorb wound discharge, cushion the wound area, and protect against further harm) and wrap with roll gauze (a long, soft, absorbent, and usually non-sterile fabric that was rolled up and used to hold dressings in place) daily for 14 days every day shift. During a review of Resident 1 ' s Interdisciplinary Team (IDT) Wound Management Care Plan Note dated [DATE] timed at 10 AM, the Note indicated Resident noted with episodes of scratching skin leading to open wounds. re-oriented, re-direction, and frequent reminder to not scratch skin. The Note indicated the altered skin integrity was a right knee open scratch wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Change of Condition (COC) form dated [DATE] timed at 11:55 AM, the COC indicated the resident was noted with an open scratch wound on the right knee and right lateral knee extending to posterior area. The COC indicated Resident had periods of scratching skin resulting in an open wound. The COC indicated initial treatment included cleansing with NS, pat dry, apply medihoney, and cover with border gauze. The COC indicated the physician and responsible party (RP) were notified. During a review of Resident 1 ' s Skin Progress Report dated [DATE] timed at 3 PM, the Progress Report indicated the resident had a right lateral knee open wound measuring five (5) by six (6) centimeters (cm, used to measure the unit of length). The Progress Report indicated the wound bed description with epithelial tissue (the lining and covering tissue of your body, forming a protective barrier and performing functions) with tan and reddened areas. The Progress Note indicated there was no drainage or odor and the wound care specialist (WCS) was notified. During a review of the same Skin Progress Report dated [DATE] timed at 3 PM, the weekly progress report indicated Resident 1 had a right lateral knee vascular wound (a sore or ulcer that developed due to problems with blood circulation, particularly in the legs and feet) measuring eight (8) by 13 cm with epithelial tissue. The Progress Report indicated Resident 1 ' s wound increased in size and had areas of tan wound bed with dark discoloration around scratch marks. The Progress Report indicated the WCS was notified and WCS had clarified Resident 1 ' s wound from an open scratch wound to a PVD on [DATE]. The same Progress Report indicated a weekly progress report section with an added date of [DATE] that further indicated WCS recommended to do a doppler ultrasound on Resident 1. During a review of Resident 1 ' s Non-Pressure Sore Skin Problem Report dated [DATE] timed at 2:57 PM, the Skin Problem Report indicated the Resident 1 had a right knee open scratch wound measuring 3 x 3 cm. The Skin Problem Report indicated to keep the right knee open scratch wound clean and dry, handle gently and slow, and to remind the resident not to scratch. During a review of the same Non-Pressure Sore Skin Problem Report dated [DATE] timed at 2:57 PM, the Skin Problem Report also included a weekly progress report section dated [DATE]. The weekly progress report indicated the resident had a right knee open scratch wound that measured 3 x 3 cm. The weekly progress report indicated the wound bed was red in color, but no changes were identified and to continue with the current treatment. During a review of Resident 1 ' s Wound Care Note dated [DATE], and authored by WCS, the Wound Care Note indicated Resident 1 had a right knee extending to posterior knee (back of the knee joint) self-inflicted (caused by one ' s own actions) scratches and excoriations (a scrape or scratch to the skin). The Wound Care Note indicated the tissue was 100% superficial with scant (barely or scarcely enough) serosanguineous (a fluid, often from a wound that contains both blood and the clear, watery part of blood) drainage and did not have an odor, was not infected, and the resident was not in pain. The Wound Care Note indicated the wound was fragile (easily damaged), scar, and discolored. The Wound Care Note indicated to apply medihoney daily. During a review of Resident 1 ' s PVD Ulcer Behavior Problem Care Plan dated [DATE], the Behavior Care Plan indicated a goal for the resident ' s PVD Ulcer to decrease in size one cm per month, would heal without complications, and be free from infection. The Care Plan interventions indicated to keep skin clean, dry, and provide skin care maintenance, provide behavior management techniques, and report any unusual drainage or order to the physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Wound Care Note dated [DATE] (no time), authored by WCS, the Wound Care Note indicated The resident did have a history of peripheral vascular disease (PVD or PAD) and the resident was on a low air loss mattress (a medical-grade mattress designed to prevent and treat pressure sores by maintaining a cool, dry environment through constant airflow). The Wound Care Note indicated the resident had a right knee extending to posterior knee self-inflicted excoriations to right lower extremity peripheral vascular wound with multiple superficial openings. The Wound Care Note indicated the tissue was 100% superficial with scant serosanguineous drainage and did not have an odor, was not infected, and the resident was not in pain. The Wound Care Note indicated the wound was fragile, scar, and discolored and to apply medihoney daily. During a review of Resident 1 ' s Right Knee Open Scratch Wound Care Plan dated [DATE], the Care Plan indicated a goal for the resident ' s wound to decrease in size one (1) cm per month, would heal without complications, and be free from infection. The Care Plan interventions indicated to keep skin clean, dry, and provide skin maintenance, provide behavior management techniques, and provide treatment per physician order. During a review of Resident 1 ' s Right Lateral Knee Extending to Posterior PVD Ulcer Care Plan dated [DATE], the Care Plan indicated a goal for the resident ' s PVD ulcer to decrease in size one cm per month, would heal without complications, and be free from infection. The Care Plan interventions indicated to keep skin clean, dry, and provide skin care maintenance, provide behavior management techniques, and to report any unusual drainage or order to the physician. During a review of Resident 1 ' s COC dated [DATE] timed at 8 AM, the COC indicated the resident was noted to be weak in appearance with ALOC. oxygen saturation of 86 to 90% with oxygen at three liters per minute (LPM). The COC indicated the resident was also noted with an open scratch wound on the right knee and right lateral knee extending to posterior aspect. The COC indicated emergency services was requested and Resident 1 was transferred to the GACH 2 for further management and treatment. During a review of Resident 1 ' s Physician ' s Order dated [DATE] timed at 9:58 AM, the Physician ' s Order indicated to transfer Resident 1 via emergency services to the GACH 2 for further management and treatment of ALOC, decreased oxygen saturation, bradycardia (a heart rate that was slower than normal, generally under 60 beats per minute), and right lateral knee wound. During a review of Resident 1 ' s Nursing Note dated [DATE] timed at 10:42 AM, the Nursing Note indicated the resident was transferred via ambulance to GACH 2 for ALOC, oxygen desaturation, and hyperglycemia (a condition characterized by high blood sugar levels). During a review of Resident 1 ' s GACH 2 Emergency Department (ED) Department Summary dated [DATE] documented at 5:42 PM, the Report indicated Resident 1 arrived at the ED on [DATE] at 10:14 AM and admitted as inpatient on [DATE] at 5:42 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s GACH 2 ED Physician Notes dated [DATE], the Physician ' s Note indicated the resident presented with weakness and poor responsiveness. The Physician ' s Note indicated Likely severe sepsis (a life-threatening condition that occurred when your body ' s response to an infection damages vital organs, often leading to death) given additional lactate (a substance produced in the body during intense physical activity or when oxygen levels were low) of 3.1 (lactate level was high if between two and four millimoles per liter [mmol/L, a unit used to measure the concentration of a substance]) but unclear source at this time. The GACH 2 ED Physician Notes indicated Suspect right lower extremity healing pressure ulcer (a localized injury to the skin and underlying tissue caused by prolonged pressure, often over body areas, leading to reduced blood flow and potential tissue damage or death) given presence of granulation tissue (a type of new connective tissue that formed in response to an injury or wound) but with central scattered punctate (characterized by or marked with small, pinpoint dots or depressions, like small, scattered spots or lesions [an area of abnormal or damaged tissue caused by injury, infection, or disease]) black discoloration . During a review of Resident 1 ' s Blood Culture Final Report dated [DATE] timed at 12:06 PM, the Report indicated the Blood Culture was growing streptococcus pyogenes (Group A strep, a common bacterium that caused a range of infections including serious, potentially life-threatening illnesses). During a review of Resident 1 ' s GACH 2 Photo #1 image dated [DATE] timed at 5:29 PM, the resident ' s right lateral lower leg had bright red discoloration lining the wound with yellow and blackish discoloration inside the wound bed and burgundy discoloration surrounding the wound. During a review of Resident 1 ' s GACH 2 Photo #2 image dated [DATE] at 5:30 PM, the resident ' s posterior right calf had bright red discoloration lining the wound with yellow and blackish discoloration inside the wound bed and burgundy discoloration surrounding the wound. During a review of Resident 1 ' s GACH 2 Photo #5 image dated [DATE] at 5:35 PM, the resident ' s right knee had broken skin with burgundy discoloration surrounding the wound. During a review of Resident 1 ' s Bilateral Lower Extremity Arterial Duplex US dated [DATE] at 5:28 PM, the US indicated Suspicion for right superficial femoral artery occlusion with poor visualization of the distal vessels (tubes or canals that carried fluid, most commonly blood) . During a review of Resident 1 ' s GACH 2 Discharge (DC) Summaries Note with documentation date of [DATE], the DC Note indicated Resident 1 was admitted on [DATE] and died at GACH 2 on [DATE] timed at 1:03 PM. The DC Summaries Note indicated the following information as indicated for Resident 1 ' s GACH 2 Admission Diagnoses: 1. Acute Kidney Injury 2. Cellulitis of the leg 3. Hyperglycemia 4. Septic Shock 5. Right lower extremity gangrenous changes (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	6. PAD The DC Summaries Note further indicated Resident 1 ' s discharge diagnoses were consistent with admission diagnoses, in addition to failure of thrive (a syndrome of unexplained weight loss, malnutrition, and disability) and complication by death. During a review of Resident 1 ' s Certificate of Death, the Certificate indicated Resident 1 ' s date of death was [DATE] (two days after Resident 1 ' s transfer from the facility to GACH 2). The Certificate indicated Resident 1 ' s cause of death included cardiopulmonary failure (when the heart suddenly stops pumping blood, and the lungs stop breathing effectively, leading to a loss of consciousness and potentially death if not treated immediately), septic shock, and CVA. During a telephone interview on [DATE] at 2:06 PM, Resident 1 ' s responsible party (RP) stated the GACH 2 ED nurse called her and stated GACH 2 were going to admit Resident 1 on [DATE]. The GACH 2 ED nurse stated to the RP that Resident 1 was pointing to his leg and mentioned there was a bad wound on his leg. The ED nurse stated to the RP that the GACH 2 medical staff stated there was gangrene (a serious condition where tissues died due to a lack of blood supply) on the resident ' s legs and Resident 1 had sepsis. The RP stated the GACH 2 ED Nurse informed her that GACH 2 had to run more tests to confirm what was going on with Resident 1 on [DATE]. During an interview on [DATE] at 2:44 PM, the Treatment Nurse (TN) stated he did not observe any signs of gangrene on Resident 1's right leg prior to the resident transferring to GACH 2 on [DATE]. The TN stated there were bruised areas because of deep scratches to the right leg and the WCS ordered a doppler on [DATE], but Resident 1 was transferred to the GACH 2 before the doppler test could be performed. The TN stated on [DATE], Resident 1 ' s wound got bigger and that was the reason why she reported the change in the condition of the wounds to the WCS who came to re-assess the resident ' s wound. During a telephone interview on [DATE] at 12:29 PM, the WCS stated Resident 1 had self-inflicted scratches from [DATE] but did not have gangrene. The WCS stated the resident had PVD and had discolored skin because Resident 1 would keep scratching and agitating the leg wounds. The WCS stated the resident ' s wound was superficial and was not a deep wound. During an interview on [DATE] at 9:14 AM, the TN stated Resident 1 had a history of intermittent claudication on bilateral lower extremities and based off that, the resident had PVD which the WCS clarified her diagnosis of the wounds on [DATE], prior to Resident 1 ' s transfer to GACH 2. During a concurrent interview and record review of Resident 1 ' s PVD Ulcer Behavior Problem Care Plan dated [DATE], on [DATE] at 9:25 AM, the TN stated he knew Resident 1 had an issue with scratching and the facility treated the scratching as a behavioral problem because he would just do it (scratch). The TN stated the facility would offer the resident activities as a distraction to the behavior. The TN stated there was no other care plans developed for Resident 1 ' s PAD/PVD prior to [DATE]. (continued on next page)

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Broadway Manor Care Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During the same concurrent interview and record review of Resident 1 ' s Right Knee Open Scratch Wound Care Plan dated [DATE], on [DATE] at 9:25 AM, the TN stated the resident ' s right knee wound could have been prevented if the facility communicated better and if the facility asked Resident 1 why he was scratching, if something was bothering him, or if his knee was painful. The TN stated there was no documented evidence that the facility conducted a root cause analysis or IDT prior to the incident as to why the resident was scratching. The TN stated the resident would scratch his forehead, arms and legs, and Resident 1 ' s scratching went down to his lower extremities - knees. During a concurrent interview and record review of Resident 1 ' s PVD Ulcer Behavior Problem Care Plan dated [DATE], on [DATE] at 10:54 AM, the Assistant Director of Nursing (ADON) stated the resident ' s scratching could be a behavioral problem because he had a diagnosis of behavior issues prior to admission and was being followed by a psychiatrist (a medical doctor who specialized in mental health, trained to diagnose, treat, and prevent mental, emotional, and behavioral disorders, often prescribing medication and offering therapy). The ADON stated if the interventions were not documented, then the interventions were not done. The ADON stated if the interventions were not provided the facility was unable to address the resident ' s behavior properly which could lead to a change of condition and if the scratch were severe, Resident 1 could have an open wound or infection. The ADON stated there was no documented evidence that the facility conducted a root cause analysis or IDT prior to the incident as to why the resident was scratching. During an interview on [DATE] at 10:10 AM, the Assistant Director of Nursing (ADON) stated the facility checks the GACH 1 DC Summary and hospital records to determine the diagnoses for the facility. Once a list was generated the physician checks all the diagnoses, would co-sign the form, and help categorize the diagnoses on the facility ' s Cumulative Diagnoses List. During a concurrent interview with the ADON and record review of Resident 1 ' s GACH 1 DC Summary dated [DATE], on [DATE] at 10:15 AM, the GACH 1 DC Summary indicated one of the resident ' s problems included PAD. The ADON stated she was unsure why the facility ' s admission records and diagnoses did not include PAD. The ADON stated PAD should have been included as a diagnosis because PAD was written on the GACH 1 DC Summary. During a concurrent interview with the ADON, and record review of Resident 1 ' s facility Cumulative Diagnosis List dated [DATE], on [DATE] at 10:26 AM, the Cumulative Diagnosis List did not include PAD as one of the resident ' s diagnoses upon admission and while residing at the facility. The ADON stated the PAD diagnosis should have been on the Cumulative Diagnosis List to have a better understanding of the resident ' s background for the physicians and nurses to monitor and watch Resident 1 closely. The ADON stated if the resident ' s PAD diagnosis was unknown there could have been a delay in treatment or symptom management to Resident 1 and the resident could have a change in condition. During a concurrent interview and record review of Resident 1 ' s developed Comprehensive Care Plans from readmitted d [DATE] to [DATE], on [DATE] at 11:05 AM, the ADON stated Resident 1 did not have a care plan for PAD, that included the recommendations to refer for a lower extremity arteriogram and intervention and Atherosclerosis and was unsure if the facility missed these diagnoses. Dur [TRUNCATED]