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	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Manor Care Center	605 West Broadway Glendale, CA 91204

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interviews and record reviews, the facility failed to ensure Licensed Vocational Nurse [LVN] 1 and Registered Nurse Supervisor (RNS) 1 consulted and notified the attending physician (Physician 1) and/or Physician Assistant (PA) 1 of a resident's significant change in condition (refers to a major decline in a resident's health status that requires a comprehensive reassessment that is not expected to resolve on its own or through standard medical interventions) for one of two sampled residents (Resident 1) in accordance with Resident 1's physician's order and care plan developed to monitor Resident 1 and notify the physician for adverse reaction (unwanted, unexpected, or harmful effect resulting from a medication or other treatment), while receiving Eliquis (a brand of anticoagulant [blood thinner] medication that prevents or reduces blood clots) from [DATE] to [DATE]. Facility licensed staff that included RNS 1 and LVN 1 failed to promptly notify Physician 1 or PA 1 for Resident 1's significant change in mental status, shortness of breath, vomiting and bleeding in resident's orifice (an opening through which something may pass) on [DATE], as indicated in the physician's order. On [DATE], Resident 1 experienced altered level of consciousness (ALOC - refers to a change in a person's mental status) and three episodes of coffee-ground (a vomit that contains bits of food of what looks like coffee grounds due to presence of old blood, that may be coming from the stomach and may be a sign of a serious problem) emesis (forceful expulsion of stomach contents through the mouth) at 9 AM, 11:30 AM, and 1:25 PM. As a result of this deficient practice, RNS 1 called [DATE] emergency medical services (EMS - a system that responds to emergencies in need of highly skilled pre-hospital clinicians) on [DATE] at 1:25 PM and Resident 1 was transferred to the General Acute Care Hospital (GACH 1), after developing shortness of breath, hypotension (abnormally low blood pressure [BP] level, below ,d+[DATE] millimeters of mercury [mm/Hg - a unit that measures pressure]) with a BP of ,d+[DATE] mm/Hg, oxygen saturation (amount of oxygen circulating in the blood; [normal levels between 95% to 100%]) of 86% in room air (the normal air a person breathes). Additionally, this failure resulted in a delay of Resident 1's diagnosis, care, and immediate/emergency interventions on [DATE] from 9 AM to 1:25 PM (4.25 hours), when EMS arrived at the facility around 1:38 PM. The EMS report indicated Resident 1 had coffee ground emesis prior to EMS arrival at the facility and was in respiratory failure (a serious condition that makes it difficult to breathe on your own) upon EMS arrival to the facility, suctioned multiple times and performed cardiopulmonary resuscitation (CPR- an emergency treatment that's done when someone's breathing or heartbeat has stopped) by EMS during transport to GACH 1. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 1:55 PM, upon EMS arrival at GACH 1, resuscitation efforts (procedures aimed at reviving someone after their heart and/or breathing has stopped) continued, but Resident 1 passed away and pronounced dead at GACH 1 on [DATE] at 2:44 PM. The EMS report indicated Presumed Etiology (the cause of a disease) of Resident 1's cardiac arrest (when heart stopped beating) was Respiratory/Asphyxia (a condition where the body doesn't get enough oxygen due to a problem with breathing or inhaling). On [DATE] at 5:33 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) in the presence of the Administrator (ADM) and Director of Nursing (DON) regarding the facility's failure to notify Physician 1 or PA 1 of Resident 1's significant change of condition, in accordance with the facility's policy & procedure (P&P) on Change of Condition Notification and physician order to notify the physician for adverse reactions as a result from the use of Eliquis. The surveyor notified the ADM of the IJ situation on [DATE] at 5:33 PM, due to LVN 1 and RNS 1 failures to consult and notify Physician 1 or PA 1 of a resident's significant change in condition on [DATE]. On [DATE] at 1:49 PM, the ADM provided CDPH with an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 3:18 PM, the surveyor notified the ADM and the DON that the IJ was removed based on onsite verification/confirmation of the facility's full implementation of the IJ Removal Plan (a detailed plan to address the IJ findings) through observations, interviews, and record reviews. Following the removal of the IJ, the facility's noncompliance remained at a scope (refers to how widespread a deficiency is) and severity (level of harm) of G (isolated [one or a very limited number of residents are affected], actual harm, that is not immediate jeopardy). The acceptable IJ Removal Plan included the following: 1. On [DATE], the DON and Assistant DON (ADON) notified the nursing staff (all licensed nurses) of findings outlined in the IJ dated [DATE] and conducted in-services for all nursing staff (21 licensed nurses and 42 certified nursing assistants (CNAs) regarding the Change of Condition policy. The training covered: a. Utilizing the Interact (electronic records software) early warning toll-stop and watch technique to report any possible resident's changes in condition. b. Utilizing the SBAR [Situation, Background, Assessment, Recommendation] form to record the change of condition to ensure accuracy and completeness that included current vital signs ((measurable indicators that reflect a person's basic physiological functions and overall health status), detailed description of the identified situation, any drainage observed, interventions provided including physician notification. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. A physician's order dated [DATE], to administer Eliquis Oral Tablet 2.5 milligrams (mg, unit of measure) give 1 tablet by mouth two times a day for deep vein thrombosis (DVT -a condition where a blood clot forms in a deep vein, typically in the lower legs or thighs) prophylaxis (action taken to prevent disease). b. A physician's order dated [DATE], to monitor anticoagulation medication (Eliquis) for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy (lack of mental alertness, sleepy), bruising, sudden changes in mental status and/or vital signs, shortness of breath, bleeding in any orifice, and abnormal labs; to document 'N' (No), if monitored and none of the above observed. Document 'Y' (Yes), if monitored and any of the above observed. The order indicated to notify physician and document in nurses' progress notes, every shift. During a review of Resident 1's Change of Condition (COC) Form - Situation Background Assessment Recommendation (SBAR) dated [DATE] timed at 1:25 PM, written by LVN 1, the SBAR indicated on [DATE] at 7:10 AM, Resident 1 was seen in bed by LVN 1 with chest rising up and down, responsive to verbal and tactile stimuli (any form of touch or physical contact that is perceived by the skin), resident was provided breakfast and ate 20% of breakfast . The SBAR indicated at 8:42 AM, Resident 1's vital signs obtained during medication administration indicated a BP at ,d+[DATE], pulse at 76 beats per minute (normal rate between 60 to 100 beats per minute), respiratory rate (normal rate between 12 to 20 breaths per minute) of 18 breaths per minute, oxygen saturation of 97% on room air, no pain, temperature of 97.8 degrees Fahrenheit (F, unit of measurement - normal range of temperature between 96 to 99 degrees Fahrenheit). Resident 1 received all due medication administered as ordered by the physician with no ASE (adverse side effects) noted. The SBAR indicated that at 9 AM, Resident 1 remained in bed awake and was assisted with activities of daily living (ADLs - basic tasks individuals perform daily for self-care and personal independence, such as bathing, dressing, toileting, and eating) by the CNA. The SBAR indicated Resident 1 had one episode of emesis. The SBAR indicated that at 11 AM, Resident 1 was in bed with nonlabored (easy, effortless, and comfortable) breathing, awaken to administer due medication. No ASE noted. resident kept clean and dry and comfortable. The SBAR further indicated that at 11:30 AM, Resident 1 had another episode of emesis, no shortness of breath (SOB) or distress noted. The SBAR further indicated that at 12:40 AM, Resident 1 was in bed sitting up and awake, the CNA (unknown) tried to assist with lunch and Resident 1 did not eat. The SBAR noted Resident 1 was left in bed with the head of bed (HOB) elevated with bed in the lowest position, call light within reach. The SBAR further indicated that at 1 PM, During rounds, [Resident 1] was in bed, no SOB or pain or discomfort noted. The SBAR further indicated that at 1:25 PM, during [RNS 1] rounds, Resident 1 was noted with SOB and pale skin color. Vitals signs obtained with BP at ,d+[DATE] mm/Hg, pulse was 81 beats per minute, respiratory rate at 17 breaths per minute, oxygen saturation was 87% on room air and 92% with non-rebreather mask (an oxygen mask that delivers high concentrations of oxygen) at 15 liters (L, unit of measure) per minute . The SBAR indicated 911 emergency services was called due to Resident 1's desaturation (abnormal drop in blood oxygen levels) and hypotension. The SBAR further indicated that EMS arrived (no time indicated) and took over. The SBAR indicated, during EMS assessment the resident had one more episode of emesis. The SBAR Note indicated Resident 1's Physician Assistant (PA 1) was made aware and Family member (FM) 1 was notified. The SBAR indicated that at 1:36 PM, Resident 1 was transferred to GACH 1 via 911 EMS. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Transfer Record dated [DATE] timed at 1:30 PM, handwritten by RNS 1, the Transfer Record indicated Resident 1's reason for transfer were ALOC, desaturation, and three episodes of emesis. The record indicated Resident 1's vital signs were temperature of 97.4 F, pulse 118 beats per minute, respiratory rate was at 17 breaths per minute, BP was at ,d+[DATE] mm/Hg, and oxygen saturation of 86%. The Transfer Record indicated Resident 1's additional reason for transfer was altered mental status (a general term referring to a change to your average mental function), weakness, and shortness of breath. During a review of Resident 1's EMS Report dated [DATE], the EMS Report indicated upon EMS arrival to the facility at 1:32 PM, Resident 1 was lying in bed. The EMS report indicated a facility staff (unknown staff) stated they contacted EMS due to resident being altered (any condition which is significantly different from a normal waking state) approximately one hour prior to EMS arrival. The EMS report indicated Resident 1 was found in respiratory failure and ventilated (to force air in and out of the lungs of a person who cannot breathe easily on their own), with bag-valve-mask (BVM, a medical device used to provide air and oxygen to person who are not breathing or breathing adequately). The EMS report indicated Resident 1 was hypotensive and apneic (breathing is interrupted by the airway blocking the flow of air) and lifted onto the gurney (wheeled stretcher) and loaded into the ambulance. The EMS report indicated [Resident 1] had coffee ground emesis prior to EMS arrival (at the facility) and was suctioned multiple times throughout treatment and transport. During a review of Resident 1's GACH 1 record titled Emergency Documentation dated [DATE] documented at 3:12 PM, the GACH 1 record indicated Resident 1 was presented in by EMS to GACH 1 for cardiac arrest. The GACH 1 record indicated that according to EMS verbal report, the facility reported to EMS that [Resident 1] was altered from this ([DATE]) morning and was also noted to have coffee-ground emesis around his mouth. The GACH 1 record indicated upon EMS arrival to GACH 1, [Resident 1] was found to be in respiratory arrest (a state in which a patient stops breathing but maintains a pulse) and shortly thereafter, went into cardiac arrest. During a telephone interview with Family (FM) 1 on [DATE] at 2:07 PM, Family 1 stated she received a call from RNS 1 on [DATE] at around 1:27 PM to inform FM 1 that EMS was called for Resident 1 due to low oxygen saturation and blood pressure. Family 1 stated she was informed by RNS 1 that Resident 1 was fine the morning of [DATE], until staff noticed Resident 1's BP and oxygen saturation were low. FM 1 stated RNS 1 did not mention any other symptoms from Resident 1. FM 1 stated she requested for a verbal report of what happened to Resident 1, from the facility and was told later by the former Director of Nursing (DON 2) that Resident 1 had vomited. FM 1 stated when FM 1 was cleaning out Resident 1's belongings, Resident 1's roommate at that time (on [DATE]) told FM 1 that the CNAs got Resident 1 out of bed to use the bathroom. Family 1 stated that facility staff have never taken Resident 1 to the bathroom. FM 1 stated she was unsure if the facility gave FM 1 a reliable report about what happened to Resident 1 on [DATE]. FM 1 stated she received a copy of Resident 1's EMS report and was questioning what really happened that day. Family 1 stated if the facility noticed the coffee ground emesis, why would the facility's licensed nurses not act upon Resident 1's change in condition right away? Family 1 stated she felt the facility's licensed nurses should have done something to help Resident 1 sooner. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview on [DATE] at 3:17 PM with LVN 1 and record review of Resident 1's COC and SBAR notes dated [DATE] documented at 1:25 PM, LVN 1 stated she documented Resident 1's SBAR on [DATE]. LVN 1 stated Resident 1 had an episode of emesis at 9 AM and 11:30 AM, however, LVN 1 stated she could not recall the color and consistency of Resident 1's emesis. LVN 1 stated after lunch on [DATE], RNS 1 was doing her rounds and saw Resident 1's oxygen saturation was under 90%. LVN 1 stated she could not recall the exact time RNS 1 found Resident 1 and stated Resident 1 was given oxygen supplement via non-rebreather mask and was effective because Resident 1's oxygen saturation level was going back up. LVN 1 stated she could not recall what Resident 1's vital signs were. LVN 1 stated she could not recall who called the EMS on [DATE]. LVN 1 stated Resident 1 was confused most of the time and was alert and oriented to only his name. LVN 1 stated she was in Resident 1's room when EMS arrived, and they took over care Resident 1. LVN 1 stated Resident 1 had vomited but could not recall what the vomit looked like, including the color of Resident 1's vomit. LVN 1 stated Resident 1's vomiting occurred during the time the EMS was in the facility and LVN 1 stated she could not recall if Resident 1 had any other episodes of emesis earlier that day. LVN 1 stated if a resident would have 2 to 3 episodes of emesis, the licensed staff would monitor the resident and report to the physician. LVN 1 stated she did not remember calling Resident 1's physician or PA 1. LVN 1 stated she could not recall much of what happen to Resident 1 on [DATE]. LVN 1 stated Resident 1 could not recall if Resident 1 had other symptoms earlier that morning of [DATE]. During an interview with RNS 1 on [DATE] at 3:31 PM, RNS 1 stated she arrived at the facility for work at 12:30 PM on [DATE]. RNS 1 stated she conducted her resident rounds and noticed Resident 1's skin was pale and had shortness of breath. RNS 1 stated she took Resident 1's vital signs and Resident 1's BP was low. RNS 1 stated Resident 1's systolic pressure (the top number in blood pressure) was below 90 mm/Hg and could not recall if she documented Resident 1's low BP in the resident's record. RNS 1 stated that on [DATE] when RNS 1 saw Resident 1, Resident 1 was not alert or talking. RNS 1 stated she placed Resident 1 on oxygen via a non-rebreather mask. RNS 1 stated when the EMS arrived at the facility, Resident 1 had an episode of emesis that appeared dark. RNS 1 stated she could not recall if Resident 1 had an episode of emesis earlier that day, on [DATE]. RNS 1 stated if resident had an episode of emesis, per protocol she would notify the physician. RNS 1 stated she remembered notifying Resident 1's family and PA 1 after 911 EMS took Resident 1 to GACH 1. During an interview with LVN 1 on [DATE] at 4:03 PM, LVN 1 stated she recalled seeing emesis on the gurney Resident 1 was transferred onto by EMS but could not recall what Resident 1's emesis looked like. LVN 1 stated she still could not recall Resident 1's episodes of emesis as documented in Resident 1's SBAR note on [DATE]. LVN 1 stated that if Resident 1 had episodes of emesis earlier that day, on [DATE], LVN 1 acknowledged that she would have notified the physician. LVN 1 stated Resident 1 could have an underlying condition, and she should have documented Resident 1's vital signs and a description of the emesis episodes at the time. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled First Aid Treatment-Crash Cart/Emergency Response dated ,d+[DATE], the P&P indicated to contact the EMS immediately for the following situations: unconsciousness or altered consciousness, difficulty or absence of breathing, severe bleeding, vomiting blood or blood in stool, condition is not clear or is worsening. The P&P indicated regardless of the nature or severity, any resident's injury/situation shall be reported to the resident's attending physician and family and documented in the resident's medical record. During a review of the facility's P&P titled Change in a Resident's Condition or Status dated ,d+[DATE], the P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been a (an): significant change in the resident's physical/emotional/mental condition; need to transfer the resident to a hospital/treatment center; specific instruction to notify the physician of changes in the resident's condition. The P&P indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the SBAR Communication form.