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	05/26/2026

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 - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and care in accordance with professional standards of practice (established guidelines or requirements for safe and accountable practice, protecting both the public and the profession's reputation) for one of three sampled residents (Resident 1) by failing to assess the resident and notify the physician when the resident had a change of condition on 5/9/2026. Specifically, Resident 1 was noted with swelling and skin discoloration on right upper arm on 5/9/2026 however there was no documentation indicating that the attending physician was informed regarding the situation or discussion of possible cause of the condition change to further consideration of appropriate diagnostic test/treatment/intervention for Resident 1 until 5/13/2026, when the X-ray result indicated a displaced right humeral fracture and Resident 1 was transferred to general acute care hospital (GACH) for evaluation. This deficient practice had resulted in Resident 1's physician unaware of Resident 1's change of condition and therefore delayed necessary medical intervention including immobilization, and the facility continued to provide restorative nursing service (RNS) and assist Resident 1 out of bed via Hoyer lift transportation to shower on 5/11/2026 with the resident's displaced right humeral fracture. Findings: During a review of Resident 1's admission Record (AR), the AR indicated that Resident 1 was initially admitted to the facility on [DATE] and lately readmitted on [DATE] with diagnoses including displaced fracture of greater tuberosity of right humerus (the bony prominence at the top of the upper arm bone is broken and pulled out of position by the attached rotator cuff tendons [a group of muscles and tendons that surround the shoulder joint]), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimal Data Sheet (MDS- a federally mandated resident assessment tool) dated 4/24/2026, the MDS indicated that Resident 1 had functional limitation in range of motion (ROM- the extent of movement of a joint) in bilateral upper extremities (BUE) and bilateral lower extremities (BLE). The MDS also indicated that Resident 1 was dependent (helper does all of the effort) on shower/bath, upper/lower body dressing, and tub/shower transfer. During a review of the Resident 1's Licensed Nurses Note (LNN) Type Change of Condition dated 5/9/2026, the LNN indicated by the licensed vocational nurse (LVN) 1 that Resident 1 was on new monitoring for swelling on right anterior bicep (a large, thick muscle on the upper arm's front portion) with discoloration and no further change in skin integrity noted. The LNN also indicated that a voice message was left for Resident 1's attending physician (Physician 1). During a review of Resident 1's Hospice PRN (as needed) Visit Summary (HVS) dated 5/9/2026, the HVS indicated that facility for PRN visit due to Resident 1's right arm swelling with edema (swelling from fluid trapped in body's tissues). The HVS indicated normal temperature no redness noted. The HVS did not indicate specifically Physician 2 was made aware of and the physician's response. During a review of Resident 1's Care Plan Edema/Swelling Right Arm dated 5/12/2026, the Care Plan interventions indicated to assess and document color, odor, consistency, edema, and pain; to elevate affected extremity per MD (medical doctor) order; to handle affected extremity gently; to medicate as ordered; to monitor for pain and discomfort. During a review of Resident 1's LNN dated from 5/10/2026 to (continued on next page)

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
	055670	A. Building B. Wing	05/26/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	5/11/2026, since after LVN 1 left voice message for Physician 1 on 5/9/2026, there was no documentation in the LNN indicating that Resident 1's physician responded or was contacted or notified regarding the swelling and skin discoloration on right upper arm. During a review of Resident 1's Restorative Nursing Orders (RNO) dated from 5/1/2026 to 5/31/2026, the RNO indicated PROM (passive range of motion) treatment BUE/BLE was provided 5/11/2026 and 5/12/2026. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 5/12/2026, timed 11AM, the SBAR indicated by the treatment nurse (TXN) 1 that Resident 1 was noted with increased discoloration and swelling to right arm. The SBAR further indicated that hospice was contacted and no new orders were received at this time. The SBAR indicated that physician was notified on 5/12/2026 at 11AM. During a review of Resident 1's Orders Summary Report (OSR) dated 5/14/2026, the OSR indicated to transfer to general acute care hospital (GACH) 1 for further evaluation and management of right humeral neck fracture (fx- break in the bone). The order did not indicate to hold providing PROM to REisdent 1's BUE and BLE. During a telephone interview on 5/22/2026 at 11:19 AM with the restorative nursing assistant (RNA) 1, RNA 1 stated that on 5/11/2026 she performed PROM for Resident 1's BUE and BLE and was not informed to hold off providing the PROM specifically Resident 1's right arm. During a concurrent record review and interview on 5/22/2026 at 11:59 AM with LVN 1, LNN was reviewed. LVN 1 stated that she paged Resident 1's attending physician and left a voice message regarding the change of condition on 5/9/2026 and endorsed to next shift. LVN 1 stated she did not perform mobility assessment on Resident 1 because Resident 1's skin discoloration and swelling were slight, and she was not endorsed for any incident that happened on Resident 1. LVN 1 also stated that she was not endorsed on 5/12/2026 regarding call back of Resident 1's physician and she did not clarify or make attempts to contact Resident 1's physician about the change of condition. During a telephone interview on 5/22/2025 at 12:25 PM with LVN 2, LVN 2 stated that she was assigned to Resident 1 on 5/11/2026 and 5/12/2026. LVN 2 stated she was endorsed for monitoring skin discoloration and swelling but she was not endorsed specifically for the size or measurements. LVN 2 stated she did not make attempt to call Resident 1's physician since she was not endorsed about it. LVN 2 further stated she notified her treatment nurse (TXN) 1 on 5/12/2026 as she noticed the swelling and discoloration on Resident 1's right upper arm appeared larger than the previous day. During an interview on 5/22/2026 at 2:29 PM with TXN 1, TXN 1 stated that she was notified about skin discoloration initially on 5/11/2026 and she was notified of it got bigger and a little more swollen on 5/12/2026. TXN 1 stated however her focus was about Resident 1's skin discoloration and did not assess Resident 1's pain and mobility. During a telephone interview on 5/22/2026 at 2:49 PM with the hospice home health aide (HHA) 1, HHA 1 stated that he visited Resident 1 on 5/8/2026 and used Hoyer Lift () to transport the resident to a shower chair with a male CNA. HHA 1 stated he did not remember the name of the male CNA. HHA 1 stated that he also visited Resident 1 and provided care and shower on 5/11/2026 and noticed the discoloration and swelling on her right upper arm. HHA 1 stated the staff did not inform him not to transfer Resident 1 out of bed for shower on 5/11/2026. During an interview on 5/22/2026 at 3:09 PM with the registered nurse supervisor (RNS) 1, RNS 1 stated she was informed about Resident 1's skin discoloration on 5/9/2026 during her shift and she noticed Resident 1's right upper arm appeared slightly edema (), and the discoloration was red-brown color like bruise. RNS 1 stated she assumed LVN 1 performed thorough assessment on Resident 1. RNS 1 stated she did not speak with the physician during her shift, and she did not work the next day. During an interview on 5/22/2026 at 3:40 PM with the director of nursing (DON), the DON stated there was no physician's order on 5/9/2026 in regard to what to specifically monitor on Resident 1 after the COC was noted. The DON stated there was no documentation in Resident 1's medical record dated from 5/9/2026 to 5/22/2026 from indicating the details on facility staff notified Resident 1's physician and the physician's response or any given order. During a telephone interview on 5/28/2026 at 10:35 AM with the Hospice (continued on next page)

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	05/26/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Nurse (HLN), HLN stated during a visit to Resident 1 on 5/9/2026 she noted the resident's right upper arm with swollen and edema. HLN stated she also noticed light green discoloration around one centimeter by one centimeter on Resident 1's right upper arm. HLN stated there was no documentation about details that she informed Physician 2 on the phone. HLN stated she did not inform Physician 2 about the light green discoloration on Resident 1's right upper arm. HLN stated that there was no documentation of the time she made call and specific order she received from Physician 2. HLN stated she did not place a telephone order for monitoring for Resident 1. During a review of the facility's Policy and Procedures (P&P) Acute Condition Change-- Clinical Protocol revised in 3/2023, the P&P indicated the following: The nursing staff will contact the physician based on the urgency of the situation. The physician will respond in a timely manner to notification of problems or changes in condition and status. The nurse and physician will discuss and evaluate the situation. The staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, and if necessary, the physician will order diagnostic tests and evaluate the resident directly. During a review of the facility's P&P Hospice Program revised in 3/2023, the P&P indicated that it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that level of care provided is appropriately based on the individual resident's needs. The P&P also indicated responsibilities include to communicate with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day.