

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/12/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive resident specific care plan for three of eight sampled residents (Resident 4, 8 and 31) in accordance with the facility's policy and procedures. A care plan for Resident 4 and 31 was not developed for management of dementia (a progressive brain disorder that affects memory and thought process). This failure had the potential to result in the resident not to receive the necessary care needs and psychosocial needs, increased behavioral escalation, resident distress, and risk of harm. 2. A care plan for Resident 8 was not developed for the management of self inflicted wound of both hands by picking at his nails and skin using fingers on both hands. This failure had the potential to result in worsened or delayed healing of Resident 8's wound. Findings: 1. During a review of Resident 4's Face sheet (admission Record) indicated the resident was originally admitted to the facility on [DATE], with a diagnosis of but not limited to , dementia, psychotic disturbance (trouble telling what is real from what is not) and anxiety (a strong feeling of worry, nervousness, or fear). During a review of Resident 4's History and Physical (H&P) , dated 3/14/2025, indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/12/20225, indicated the resident has moderate cognitive impairment (forgetful, confused, with unreliable judgment and decision &ndash; making) dependent on helper for all activities of daily living (ADL's) such as eating, oral hygiene, toileting hygiene, showering, and dressing. During an interview on 2/12/2026 at 8:05 AM with Certified Nursing Assistant (CNA3) stated, Resident 4 has periods of confusion and forgetfulness, with episodes of irritability during which she may refuse assistance with activities of daily living (ADLs), including showering and eating. CNA 3 states that Resident 4 has safety concerns related to her cognitive impairment, requiring frequent reorientation and does not have the ability to use the call light. CNA 3 stated frequent rounding is provided for her behaviors. During a concurrent interview and record review on 2/12/2026 at 8:25AM with Registered Nurse Supervisor (RN1), Resident 1's care plans were reviewed. RN 1 stated, there was no care plan developed specific to the resident's diagnosis of dementia and associated behaviors. RN 1 stated that without a behavior &ndash; specific dementia care plan and care provided to the resident could be inconsistent. 2. During a review of Resident 31's admission record, the admission record indicated Resident 31 was (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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE] with diagnoses but not limited to dementia, depression, anxiety, and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 31's Minimum Data Set (MDS &ndash; a comprehensive resident assessment tool), dated 1/30/2026, the MDS indicated an active diagnosis of dementia. During an interview on 2/12/2026 at 8:40 AM with LVN (Licensed Vocational Nurse) 1, LVN 1 stated Resident 31 had a diagnosis of dementia and is sometimes confused and agitated. Resident 31's medical record was reviewed with LVN 1. Resident 31's medical record did not indicate a care plan for dementia. LVN 1 stated Resident 31 does not have a care plan for dementia. During an interview on 2/12/2026 at 9:01 AM with the Assistant Director of Nursing (ADON), the ADON stated Resident 31 should have a care plan for dementia. During an interview on 2/12/2026 at 9:25 AM with the MDS nurse, the MDS nurse stated it was important for residents to have dementia care plans to provide care for each resident to help with their cognitive impairment and safety. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2023, the P&P indicated the Interdisciplinary Team will develop and implement a comprehensive, person-centered care plan for each resident. 3. During a review of Resident 8's admission record indicated Resident 8 was had admitted to the facility on [DATE] and readmitted on [DATE] diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, chronic ataxia (neurological sign characterized by impaired muscle coordination that leads to unsteady movements) and type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool) dated 10/11/2025, the MDS indicated Resident 8 had moderately impaired cognition (ability to think and reason). During a review of Resident 8's Change of Condition /Interact Assessment, dated 12/21/2025, the assessment indicated Resident 8 had a self-inflicted wound with minimal bleeding from the nails and skin picking. During a review of all Resident 8's medical records, the medical records did not indicate a care plan to facilitate the treatment and monitoring of Resident 8's wound. During an observation on 2/9/2026 at 11:49 AM inside Resident 8's room, Resident 8 was picking at his nails and skin using fingers on both hands. During an interview on 2/11/2026 at 8:37 AM with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 8 picks his skin with his nails and fingers causing them to bleed. During an interview on 2/12/2026 at 8:45 AM with Treatment Nurse (TN) 1, TN1 stated there was no care plan to care and treat for Resident 8's wound that TN1 also stated Resident 8's care plan should involve wound cleaning and monitoring for signs and symptoms of infection. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2026 at 1:35PM with Assistant Director of Nursing (ADON), ADON stated the nurses didn't update Residents 8's care plan to include assessing and providing treatment for Resident 8's self-inflicted wound. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered , revised March 2023, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person -centered care plan will include measurable objectives and timeframes, describes the services that are to furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflect current problem areas and conditions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1.Reconcile (the process of comparing transactions and activity to supporting documentation) two medication emergency kits ([eKIT] - kit containing medications needed to be used during emergencies) containing lorazepam (a controlled substance [CS - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics or Controlled Medication [CM] used for anxiety) for February 2026, in one of two Medication Rooms (Medication Room Station A) inspected. 2. Account for one dose of Modafinil (a CM used to sleep apnea [a disorder where breathing repeatedly stops and starts during sleep, preventing necessary oxygen flow and restful sleep]) for Resident 4 in one of two inspected medication carts (Medication Cart 1). 3.Include the verifying signatures of two licensed nurses on the Medication Disposition Record observed in Medication Room Station A for four of four sampled records. As a result, control and accountability of medication disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. 4.Apply lidocaine (a medication used for relieving pain) patches (a medication delivery system) to one side of body to Resident 27, as ordered by the physician. These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and exposure of harmful medications to residents in the facility, that Resident 4 could have accidental overdose (administration of more than the prescribed dose) to CM possibly leading to physical and psychosocial harm, hospitalization and death and the potential to result in Resident 27's health and well-being to be negatively impacted. Findings: During an observation on 2/10/2026 at 10:10 A.M., Licensed Vocational Nurse (LVN) 4 was observed applying one lidocaine 4% patch to Resident 27's right flank (side of body below the ribs above the hips) area, and one lidocaine 4% patch to Resident 27's left flank area. During an observation and concurrent interview on 2/10/2026 at 1:10 P.M., with Registered Nurse (RN) 1, in Medication Room Station A, there was: One medication e-KIT stored in the refrigerator and labeled REF493, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026.^ One (1) medication e-KIT stored in the cabinet at room temperature and labeled 308, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026.^ Four (4) Medication Disposition Record logs, dated 1/19/2026, without witness initials for the destruction of the medications listed on the form. During a concurrent record review and interview on 1/19/2026, RN 1 reviewed four Medication Disposition Record logs and was unable to find signatures, initials, or witness names. RN 1 stated that licensed nurses did not comply with state requirements or facility policy, which indicated medication disposal entries be signed with a witness. During the same interview, RN 1 stated that all CSs, including medication e-KITs containing CSs must be reconciled every shift. RN 1 stated the e-KIT labeled REF493 and 308 in Medication Room Station A were not reconciled each shift in February 2026. RN 1 stated that consistent reconciliation is necessary to maintain accountability and prevent CS diversion. During a concurrent record review and interview, on 2/10/2026 at 3:35 P.M. with LVN 2, LVN 2 reviewed four (4) Medication Disposition Record logs dated 1/19/2026. LVN 2 stated she could not locate signatures, initials, or witness names on the records. LVN 2 stated failing to ensure that a licensed nurse initialed the log as a witness when disposing of medications on 1/19/2026. During an observation on 2/10/2026 at 1:33 P.M., with Licensed Vocational Nurse (LVN) 4, in Medication Cart 1, there was a discrepancy in the count between the Antibiotic or Controlled Drug Record accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: Two (2) doses of Modafinil (a CM used to (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sleep apnea [a disorder where breathing repeatedly stops and starts during sleep, preventing necessary oxygen flow and restful sleep]) 100 milligram ([mg] - a unit of measure of mass) tablet was missing from the bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 4. The Antibiotic or Controlled Drug Record accountability log for Modafinil indicated the bubble pack should have contained a total of 28 Modafinil 100 mg tablets, however the bubble pack contained 26 Modafinil 100 mg tablets and no documentation of administrations. During a concurrent interview, LVN 4 stated LVN 4 administered two (2) Modafinil 100 mg tablets to Resident 4 that morning (2/10/2025) at 8:38 A.M. and forgot to sign the Antibiotic or Controlled Drug Record accountability log. LVN 4 stated LVN 4 failed to follow the facility's policy of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the resident. LVN 4 stated LVN 4 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 4 stated if documentation was not accurate then it can lead to medication error if overdosed leading to stoppage of breathing, hospitalization and possibly death for Resident 4. During an interview on 2/10/2026 at 1:42 P.M., with LVN 4, LVN 4 stated during the medication administration that day (2/10/2026) at 10:10 A.M., LVN 4 applied one (1) Lidocaine 5% patch to Resident 27's right flank area, and one (1) lidocaine 5% patch to Resident 27's left flank area. LVN 4 acknowledged the physician's order specified to apply two (2) Lidocaine 4% patch to left flank area. LVN 4 stated that LVN 4 failed to follow 5 rights of medication administration and applied the lidocaine patches not according to physician orders. LVN 4 stated this was considered a medication error. During an interview on 2/10/2026 at 2 P.M., with the Director of Nursing (DON,) the DON stated that medication e-KITs containing CSs needed to be counted and reconciled at every shift change to ensure accountability and prevent CS diversion. The DON stated the e-KITs labeled REF493 and 308 containing CSs in Medication Room Station A were not reconciled at every shift in February 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of e-Kits containing CSs. During the same interview, the DON reviewed the four (4) Medication Disposition Record logs dated 1/19/2026. The DON stated the DON was unable to locate the witness initials on the logs. The DON stated licensed nurses failed to include the initials of witnesses when destroying medications. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. During the same interview, the DON stated that LVN 4 failed to follow facility policy of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Resident 4. The DON stated not documenting the Antibiotic or Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. The DON also stated that LVN 4 failed to follow five (5) rights of medication administration and facility medication administration guidelines to ensure physician orders were followed as prescribed and medications were administered correctly to Residents 27. The DON stated that LVN 4 did not administer both lidocaine patches to the left flank area of Resident 27. The DON stated not administering both patches on the left flank areas could harm Resident 27 by not relieving the pain. DON stated this was considered a medication error. During a review of Resident 4's admission Record (a document containing demographic and diagnostic information,) dated 2/10/2026, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses including respiratory (breathing) failure, Parkinson's disease (brain disorder that causes problems with movement, balance, and coordination,) epilepsy (brain disorder that causes recurring seizures,) psychosis (a mental health symptom where a person loses touch with reality,) dementia (a decline in mental ability such as memory, reasoning, and communication.) During a review of Resident 4's Medication Administration Record ([MAR - record of medications administered to a resident) for February 2026, the MAR indicated Resident 4 was prescribed Modafinil 200 mg for sleep apnea, starting 7/3/2025, to be given once a day at 9.a.m. During a review of Resident 27's admission Record (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 2/10/2026, the admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including abdominal (stomach) pain. During a review of Resident 27's MAR for February 2026, the MAR indicated Resident 27 was prescribed Lidocaine 4% patch apply two (2) patches at Left flank area for pain management, starting 11/10/2025, to be given once a day at 9 A.M. During a review of the Policy and Procedures (P&P) titled Controlled Medications, revised March 2023, the P&P indicated: When a CM is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) date and time of administration 2) amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. During a review of the P&P, titled Controlled Medication Storage, revised March 2023, the P&P indicated: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. a. The DON and the consultant pharmacist maintain facility's compliance with federal and state laws and regulations in the handling of controlled medications. b. At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. During a review of facility's P&P, titled Medication Destruction, last revised January 2025, the P&P indicated: a. Non-controlled medication destruction occurs in the presence of two licensed nurses. b. The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form signature of witnesses.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label, discard medications and stored safely, following manufacturer's recommendations and in accordance with the facility's Policy and Procedure (P&P) titled Medications and biologicals by failing to: 1.Label one (1) open Lantus (type of long-acting insulin [medication that lowers blood sugar]) in a Solostar pen (a type of prefilled syringe containing insulin) stored in Medication Cart 2 at room temperature for one of three sampled residents (Resident 83). 2. Remove from use and discard one (1) expired medication from facility stock, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medication rooms (Medication Room Station A.) These deficient practices increased the risk that Resident 83 and other residents to receive medication that had become ineffective or toxic due to improper storage or labeling, experience medication adverse consequences (unwanted, uncomfortable, or dangerous effects that a medication may have) resulting in the negative impact to their health and well-being possibly leading to health complications, hospitalization, or death. Findings: During an observation and concurrent interview on 2/10/2026 at 1:10 P.M., in Medication Room Station A with Registered Nurse (RN) 1, an unopened box of Refresh (an eye drop medication used for dry eyes) eye drops was found stored at room temperature in the cabinet with other unexpired facility stock medications was labeled with an expiration date of 12/2025. According to the manufacturer's expiration date imprinted on the Refresh medication box, the medication should be used or discarded by December 2025. During a concurrent interview, RN 1 acknowledged the Refresh eye drops for facility stock expired in December 2025 and should have been removed from use and placed in the expired medication bin to be disposed and to prevent accidental use. RN 1 stated expired medications could have less or no potency (strength) and will not be effective when used in error for residents in the facility. RN 1 stating using expired Refresh eye drops will not be effective in treating residents with dry eyes. During an observation on 2/9/2026 at 1:45 P.M., the Medication Cart 2 in the presence of Licensed Vocational Nurse (LVN) 6, one open and used insulin Lantus belonging to Resident 83 was found stored at room temperature without a date indicating when storage or use at room temperature without label, an open date as required by their respective manufacturer's specifications or stored and labeled in a manner consistent with facility policies. LVN 6 stated according to the manufacturer's product labeling, open Lantus Solostar insulin pens should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening pen. During a concurrent interview on 2/9/2026 at 1:45 p.m. with LVN 6, LVN 6 stated insulin Lantus Solostar pen for Resident 83 was open, used, stored at room temperature, and not labeled with a date when use at room temperature began. LVN 6 stated insulin pen was considered a multi-dose (having more than one [1] dose) medication and according to manufacturer recommendation the Lantus pen needed to be discarded after 28 days of use, and after that day the insulin could lose potency (the strength of medication) and considered expired. LVN 6 stated that LVN 6 was unaware when the insulin Lantus Solostar pen for Resident 83 was opened or stored at room temperature therefore unknown when it would expire. LVN 6 stated administering expired insulin in error will not be effective in keeping the blood sugar stable and can harm Resident 83 by causing high blood sugar levels, leading to shock and coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. During an interview on 2/10/2026 at 2 P.M., with the Director of Nursing (DON,) the DON stated the insulin Lantus Solostar pen for Resident 83 was not labeled with a date when the pen was first opened and used. The DON stated several LVN's failed to label the date the pen was opened and used. The DON stated without knowing when the Lantus Solostar pen was opened it was unknown when it would expire, increasing the risk of administration of expired insulin to Resident 83. The DON stated expired insulins have lost potency and effectiveness and when (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered in error were not effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar level) and potential hospitalization for Resident 83. During the same interview, the DON stated that expired medications are ineffective and may not work properly and need to be removed from use. The DON stated that several LVN's failed to remove expired Refresh eye drops from facility stock increasing the potential for use of expired medications and harming residents by not treating their condition. During a review of facility's Policy and Procedures (P&P) titled, Discontinued Medications, last revised January 2025, the P&P indicated that When medication are expired, discontinued by a prescriber, the resident is transferred or discharged .the medications are marked as discontinued or stored in a separate location and later destroyed. If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue. During a review of facility's P&P titled, Storage of Medications, last revised January 2025, the P&P indicated that Medications and biologicals are stored safely, and properly, following manufacturer's recommendations or those of the supplier the outdated, contaminated, or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of facility's P&P titled, Procedure for All Medications, revised March 2023, the P&P indicated: When opening a multi-dose container, place the date on the container. During a review of facility's P&P titled, Vials and Ampules of Injectable Medications, revised March 2023, the P&P indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials. Medication in multi-dose vials may be used until manufacturer's expiration date. During a review of manufacturer guideline, titled Highlights of Prescribing Information for Lantus, dated 6/2022, the guide indicated only use your pen for up to 28 days after its first use. Throw away the Lantus Solostar pen you are using after 28 days, even if it still has insulin left in it.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to follow the facility's policy and procedure for Sanitation and Infection Control, to ensure the Dietary Aide (DA) followed infection control policies to ensure the department operated under sanitary condition to serve 70 of 70 residents. This deficient practice had the potential to cause food-borne illnesses caused by consuming contaminated foods or beverages. Findings: During an observation on 2/11/2026 at 11:40 AM, during a tray line observation, the Dietary [NAME] (DC) when serving food and was observed wearing gloves. The DC opened the refrigerator door, took out a box, set it on the counter, and proceeded to serve a bread roll with the same gloved hand. Registered Dietitian (RD) present during tray line was made aware of the observation and instructed the DC to wash his hands and change to new gloves. During an interview on 2/11/2026 at 3:18 PM with Dietary Supervisor Department (DSD) stated that the DC should have washed his hands and change gloves before proceeding to continue to serve food. DSD stated this deficient practice could have placed residents especially those that are immune compromised are at risk for food borne illness. During a review of the facility's policy and procedure titled, Sanitation and Infection Control, undated, indicated, disposable gloves are to be worn for single use and should be discarded after each use or when soiled.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on observation, interviews and record review, the facility failed to provide sufficient training program to ensure the continuing competence of certified nursing assistants. This deficient practice had the potential to negatively impact the competence and performance of certified nursing assistants in delivering safe and effective nursing care. Findings: During an interview on 2/12/2026 at 2:10 PM with Director of Staff Development (DSD), DSD stated that nursing assistants weigh the residents, but nursing assistants were not given a training on weight assessment and there was no competency tool checklist for weight assessment. During an interview on 2/12/2026 at 2:35 PM with Restorative Nursing Assistant (RNA)1, RNA 1 stated that they do weigh the residents but cannot remember the last time training on weighing residents was given by the facility. During an interview on 2/12/2026 at 2:55 PM with Registered Nurse (RN) 1, RN 1 stated Resident 8 was weighed monthly only and was not weighed every week for the first month of Resident 8's admission. During an interview on 2/12/2026 at 3:45 PM with Assistant Director of Nursing (ADON), ADON stated nursing assistants provide care to the residents and trainings should be provided for them to be competent on their job. ADON also stated one of the nursing assistants' main tasks is to weigh the residents upon admission, every week for first month of admission and monthly thereafter. During a review of the facility's annual education calendar for 2025, the calendar for the monthly topics provided by the DSD to the staff did not include topics on weight assessment. During a review of the Certified Nursing Assistant Competency Evaluation Checklist, dated 10/10/2025, the checklist indicated there is no evaluation for competency on weight assessment in the nursing assistant skills competency. During a review of the facility's policy and procedure (P&P) titled, In-service training , all staff, the P&P indicated, the primary objective of the in-service training is to ensure the staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Training requirements are met prior to staff providing services to residents, annually and as necessary based on the facility assessment.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 1 of 7 sampled residents (Resident 48) had a current and accessible copy of the Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) in the resident's electronic chart and physical clinical record. These failures had the potential to cause conflict with Resident 48's and their representative party's wishes regarding end-of-life treatment and care. Findings: During a review of Resident 48's admission Record (AR), the facility admitted Resident 48 to the facility on 6/4/2022 and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), and heart failure (chronic condition where the heart muscle cannot efficiently pump blood to the rest of the body). During a review of Resident 48's Advance Directive Acknowledgement document, dated 9/30/2022, the document indicated Resident 48 had an Advance Directive available and indicated that the terms of the Advance Directive will be followed by the healthcare facility and my caregivers to the extent permitted by law. During a review of Resident 48's Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life), prepared by the facility on 8/17/2023 and signed by Family Member (FM) 1 on 10/10/2024, the POLST indicated Resident 48 had an Advance Directive, dated 12/14/2020, that was available and reviewed by the facility. During a review of Resident 48's Minimal Data Set (MDS, a resident assessment tool), dated 1/1/2026, the MDS indicated that Resident 48 was unable to complete the Brief interview for Mental Status. The MDS indicated that there was a staff assessment of Resident 48's mental status, and the MDS indicated Resident 48's cognitive skills (a resident's thought process) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 48's Advance Directive was not available. During an interview on 2/10/2026 at 11:45 AM with FM 1, FM 1 stated she had given the facility a copy of Resident 48's Advance Directive when Resident 48 was admitted to the facility initial admission into the facility. During a concurrent interview and record review on 2/10/2026 at 4:15 PM with the Assistant Director of Nursing (ADON), Resident 48's Advance Directive Acknowledgement form, dated 9/30/2022 and POLST, signed by FM 1 on 10/10/2024 were reviewed. The ADON stated that according to the Advance Directive Acknowledgement form and the POST, Resident 48 had an Advance Directive. During the same concurrent interview and record review on 2/10/2026 at 4:25 PM with the ADON, Resident 48's physical and electronic clinical chart were reviewed. The ADON stated, a copy of Resident 48's Advance Directive was not located in Resident 48's physical or electronic clinical chart and did not know why it was not in the resident's clinical records. During an interview on 2/11/2026 at 9:40 AM with the Social Services Director (SSD), the SSD stated, she was not aware that a copy of Resident 48's Advance Directive was not in the chart until it was mentioned to her during the recertification team's investigation on 2/10/2026. The SSD stated that it was important to have a copy of the resident's Advance Directive in the chart so the medical staff within the facility, the paramedics, and at the General Acute Care Hospital were aware of the resident's and their representative party's wishes in an event the resident is no longer cognitively intact and during an emergency situation. During a review of the facility's policy and procedure (P&P) titled Advance Directive, dated September 2022, the P&P indicated that if the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards and facility policy and procedures (P&P) for one of six residents (Resident 55) observed for medication administration by failing to administer crushed medications separately. This deficient practice increased the risk that Residents 55 could experience medication adverse effects (unwanted, unintended result) such as drug (medication) - drug interactions and cross-contamination from combining and administering crushed medications together. Findings: During an observation on 2/10/2026 at 9:35 AM with Licensed Vocational Nurse (LVN) 6, LVN 6 was observed crushing and combining the following medications in a small plastic cup for Resident 55: Amlodipine (a medication used for high blood pressure) 5 milligram ([mg] - a unit of measure of mass) tablet. Benzotropine (a medication used for Parkinsons disease [a brain disorder that causes problems with movement, balance, and coordination]) 3 mg tablet. Docusate (a medication used for constipation) 100 mg tablet. LVN 6 was then observed opening Gabapentin (a medication used for neuropathy [pain caused by damaged nerves]) 100 mg capsule and pouring the contents on top of the other crushed medications in the small plastic cup. LVN 6 added applesauce to the plastic cup and mixed all the medications together. LVN 6 confirmed that LVN 6 prepared four (4) medications for administration to Resident 55 and walked inside Resident 55's room. LVN 6 introduced herself to Resident 55 and prepared for the medication administration. LVN 6 was stopped by the surveyor before any medication was administered to Resident 55 and advised to discuss the medication preparation with the surveyor in the hallway. During an interview on 2/10/2026 at 9:40 AM, with LVN 6, LVN 6 stated that nurses should not combine crushed medications and to prepare each crushed medication separately for administration. LVN 6 acknowledged Resident 55's orders indicated may crush medications mixed with applesauce and administer as a single oral bolus starting that day. LVN 6 stated single oral bolus indicated to give each medication as a single administration. LVN 6 stated administering crushed medications combined and together could result in adverse reactions such as drug-drug interactions. LVN 6 stated that LVN 6 failed to follow standard of practice and facility P&P. During a concurrent record review and interview on 2/10/2026 at 2 P.M., with the Director of Nursing (DON,) the DON reviewed Resident 55's MAR and facility P&P titled Medication Administration - General Guidelines. The DON acknowledged Resident 55's orders indicated may crush medications mixed with applesauce and administer as a single oral bolus starting that day. The DON stated single oral bolus indicated to give each medication as a single administration. The DON stated as a standard of practice nurses should administer crushed medications separately and not combine together. The DON stated LVN 6 failed to prepare crushed medications separately for administration that day (2/9/2026) during morning medication administration, increasing the risk of medication adverse effects, and drug-drug interactions for Resident 55. During a review of Resident 55's admission Record (a document containing demographic and diagnostic information,) dated 2/10/2026, the admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including respiratory (breathing) failure, Parkinson's disease, neuropathy and hypertension (high blood pressure.) During a review of Resident 55's Medication Administration Record ([MAR] - record of medications administered to a resident) for February 2026, the MAR indicated the following for Resident: Amlodipine 5 mg tablet by mouth once a day for hypertension starting 11/14/2025, to be given at 9 A.M. Benzotropine 3 mg tablet by mouth twice a day for Parkinsons disease starting 5/15/2023, to be given at 9 A.M. and 5 P.M. Docusate 100 mg tablet by mouth once a day for stool softener starting 10/2/2021, to be given at 9 A.M. Gabapentin 100 mg capsule by mouth three (3) times a day for neuropathy starting 12/7/2020, to be given at 9 A.M., 1 P.M. and 5 P.M. May crush medications mixed with applesauce or alternative and administer as a single oral bolus, starting 2/10/2026 at 9:33 A.M. Monitor side effect of adverse effect of oral bolus administration of crushed (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, starting 2/10/2026 at 9:33 A.M. During a review of the facility's P&P titled Medication Administration-General Guidelines, revised March 2023, the P&P indicated: crushed medications should not be combined and given all at once, either orally (e.g., in pudding or other similar food) or via feeding tube. During a review of the facility's P&P titled Crushing Medications, revised March 2023, the P&P indicated: Crushing each medication separately is considered best practice. However, separating and administering crushed medication is not appropriate for all residents. Issues related to safety, needs, preferences, medication schedule, and functional ability will determine the most resident-centered approach.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 7) with limited range of motion (ROM - the extent of movement of a joint) was assessed for refusal of care and provided alternative treatment and services when resident refused to receive ROM exercises, use of hand roll splints (rigid, or semi-rigid devices used to stabilize fractured bones, injured joints, or muscles) and no alternative measures provided to prevent decline in ROM. This deficient practice had the potential to place the resident at increased risk for ROM decline and development of contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: During a record review of Resident's 7 admission Record (AR), dated the AR indicated that Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with included diagnoses of rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a record review of Resident's 7 Minimum Data Set (MDS - a resident assessment tool) dated 12/21/2025. The MDS indicated Resident 7's had no cognitive (ability to think and reason) impairment. During a record review of Resident's 7 care plan Alteration in Joint Mobility dated 12/31/2025, indicated the goal was to minimize the risk for further loss of ROM daily. The care plan interventions included to monitor the resident for pain or stiffness, provide therapy intervention as needed, position resident to prevent further contractures with pillows or splints as needed. During a record review of Resident's 7 Joint Mobility Screen, dated 6/27/2025 a quarterly review indicated that Resident 7 continued to refuse bilateral upper extremities exercises despite education on purposes of joint mobility exercises and encouragements. During a record review of Resident 7 Joint Mobility Screening (OT) Upper Extremities, dated 11/7/2025, indicated, that splints were not recommended due to flexion contractures of joints and that Resident 7 was refusing to wear hand rolls and passive ROM and due to Resident 7 refusing to participate the RNA program was discontinued. During an interview on 2/11/2026 at 9:52 AM with the Physical Therapist (PT 1), PT 1 stated Resident 7 refused to have splints applied and to do ROM exercises with the RNA's therefore the RNA program was discontinued. During an interview on 2/11/2026 at 1:05 PM with PT 1 and Resident 7, Resident 7 stated that she does not get out of bed because she cannot sit comfortably in the wheelchair or a decliner due to her poor back posture, Resident 7 stated that she is aware of her joint limitations but does have the ability to flex her elbows, move her arms up and down but can't move her fingers. Resident 7 also stated that she can lift her legs up and down but only with assistance. Resident 7 stated she would like to do simple preferred exercises. PT 1 acknowledged Resident 7 preferences and communicated to Resident 7 that PT 1 will work a plan of care customized to meet Resident 7 preferences. During an interview on 2/12/2026 at 2:08 PM with the Director of Nurses (DON), DON stated that the plan of care for any resident is to prevent further decline in the residents' condition. When a decline is not addressed this can worsen the overall health condition of the resident. The DON stated there was no alternative measures provided to the resident for the refusal of care or assessed for reason for refusal. During a review of the facility's Policy and Procedures (P&P) [NAME] Resident Mobility and Range of Motion, dated 7/2017, indicated the rehab department will identify the residents current mobility status and the residents ability to move to and from lying position, turn and move side to side in bed, change body positions, transfer to and from bed or chair, walk limitations in movement or mobility opportunities for improvement and previous treatment and services for mobility. The policy also stated that the care plan will include measurable goals and objectives and that the resident and representative will be included in determining these goals and objectives.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe and hazard free environment in accordance with facility's policy and procedure titled Oxygen Administration by failing to display a Oxygen in Use precaution on the door for one of eight sample residents (Resident 5) who was receiving oxygen. This deficient practice had the potential to place residents at risk of injury due to accidental fire and hazard. Findings: During an observation on 2/9/2026 at 9:52 AM during the initial tour, Resident 5 was lying on the bed receiving oxygen at 4 liters delivered via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) there was no sign on the resident's door indicating that oxygen was in use in Resident 5's room or that smoking was prohibited. During a record review of Resident 5's, admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizophrenia (a mental illness that is characterized by disturbances in thought). During a record review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/22/2026, indicated Resident 5 moderately impaired (Moderate problems with thinking and memory). During a record review of Resident 5's physician Orders dated 2/1/2026 indicated an order for oxygen to administer oxygen at 2 liters per minute via nasal cannula and to titrate up to 5 liters per minute for oxygen saturation of less than 90% as necessary for shortness of breath and low oxygen saturation, During an interview on 2/9/2026 with Licensed Vocational Nurse (LVN 1) stated that oxygen was on and at 4 liters and that there should have been a sign on the resident's door to communicate to everyone that oxygen was in use. During an interview on 2/12/2026 at 1:59 PM with the Director of Nurses (DON), stated that whenever there is oxygen in use for safety reasons there should be a sign posted at the entrance of the residents room to alert everyone that oxygen is in use and this is to prevent fire and or injury. During a record review of the facility's policy & procedure (P&P) titled Oxygen Administration, dated 10/2010, indicated that the purpose of this P&P is to provide safe oxygen administration. The facility must place an Oxygen in Use sign on the outside of the room entrance door.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure that one of three sample residents (Resident 2, a resident who had kidney failure (failure of the kidney to filter toxins and remove extra fluid in the body) and receives hemodialysis (dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) fluid intake restriction was monitored properly and followed the Registered Dietitian's (RD) fluid restriction recommendation of 750 to 1500 milliliters (mL, unit of measure) as indicated in the Nutritional Assessment on 1/26/2026. These failures had the potential to place Resident 2 at risk for altered hydration status which may lead to severe dehydration or fluid overload which may result in a hypotensive (low blood pressure) or hypertensive (high blood pressure) blood pressure emergency, edema (swelling), shortness of breath, heart failure (heart cannot effectively pump blood to the rest of the body) and may ultimately lead to hospitalization. Findings: During a review of Resident 2's admission Record (AR), the facility admitted Resident 2 on 12/27/2023 and readmitted Resident 2 on 1/16/2026 with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD, irreversible kidney failure), and dependence on renal dialysis. During a review of Resident 2's care plan, dated 1/24/2024, the care plan indicated that Resident 2 was at risk for chronic anemia (a condition where the body does not have enough healthy red blood cells) related to her ESRD and hemodialysis. The care plan's interventions included monitoring fluid balance and consulting a RD. During a review of Resident 2's care plan, dated 7/2/2025, the care plan indicated Resident 2 was at risk for altered fluid balance. The care plan's interventions included educating Resident 2 and representative party regarding her fluid and dietary restrictions, instructing Resident 2 regarding her fluid and dietary restrictions, and monitoring Resident 2's compliance with dietary and fluid restrictions. During a review of Resident 2's care plan, dated 11/14/2025, the care plan indicated Resident 2 may expect weight changes due to fluid retention secondary to ESRD and hemodialysis. The care plan's interventions included a registered dietitian's evaluation as needed and the staff will assess for signs and symptoms of edema or fluid overload. During a review of Resident 2's History and Physical (HP), dated 1/1/2026, the HP indicated that Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the order, dated 1/18/2026, indicated Resident 2 had a fluid restriction limited to no water pitcher at bedside. During a review of Resident 2's Minimal Data Set (MDS, a resident assessment), dated 1/20/2026, the MDS indicated that Resident 2's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 2 needed assistance (helper sets up or cleans up) for meals. The MDS indicated that Resident 2 received hemodialysis. During a review of Resident 2's Nutritional Assessment - Registered Dietitian (RD), dated 8/6/2024, 7/9/2025, 9/29/2025, and 1/21/2026, the RD's Nutritional Assessment indicated Resident 2's fluid requirement was 750 - 1500 mL. During an observation on 2/10/2026 at 4:35 PM in Resident 2's room, Resident 2 was observed sleeping in bed with small plastic cup half filled with water was noted on the overbed bedside table (a small adjustable table designed to roll over a bed and provide a flat surface). During a concurrent observation and interview on 2/11/2026 at 8:28 AM with Certified Nurse Assistant (CNA) 4 in the hallway in front of Resident 2's room, Resident 2's breakfast tray was observed. CNA 4 stated Resident 2 did not eat her breakfast and did not know how much fluids Resident 2 drank with this meal. During a concurrent observation and interview on 2/11/2026 at 1:30 PM with Restorative Nurse Assistant (RNA) 1 in the hallway in front of Resident 2's room, Resident 2's lunch tray was observed. RNA 1 stated Resident 2 ate about 80% of her meal, drank about 3/4 of her cup of milk, but did not know how much water Resident 2 drank with this meal. During an interview on 2/12/2026 at 9:30 AM in Resident 2's room with Resident 2, Resident 2 stated she did not drink any fluids last night [2/11/2026]. Resident 2 stated, she drank all her hot tea this morning and half a small plastic cup of water. During an (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 2/12/2026 at 10:20 AM in Resident 2's room, Resident 2 was observed sleeping in bed with two small plastic cups of water 3/4 full of water on the overbed bedside table. During an interview on 2/12/2026 at 10:25 AM with CNA 4, CNA 4 stated, she was unaware of any current residents who were on fluid restrictions. During an interview on 2/12/2026 at 10:30 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was important to monitor the fluid intake of a resident receiving hemodialysis to ensure the resident was drinking enough fluids to be within the fluid restriction range. LVN 1 stated that a dialysis resident had a fluid restriction order with the amount of fluids intake the resident was allowed. LVN 1 stated, the CNAs and the licensed nurses (LN) needed to be aware how which residents were on fluid restrictions. During the same concurrent interview and record review on 2/12/2026 at 10:32 AM with LVN 1, Resident 2's care plans titled Risk for Altered Fluid Balance, dated 7/2/2025, was reviewed. LVN 1 stated, Resident 2's care plan meant that she had a fluid restriction and needed to be monitored for fluid retention and fluid overload. During the same concurrent interview and record review on 2/12/2026 at 10:40 AM with LVN 1, Resident 2's Active Orders List were reviewed. LVN 1 stated, the only fluid restriction order for Resident 12 was to limit to no water pitcher at bedside. LVN 1 stated, there was no order with the specific amount of fluids Resident 2 needed to drink each shift to meet the fluid restrictions. LVN 1 stated, he did not know how much fluids Resident 2 drank this morning [2/11/2026]. During a concurrent interview and record review on 2/12/2026 at 10:55 AM with Registered Nurse (RN) 1, Resident 2's Active Orders List was reviewed. RN 1 stated, Resident 2's fluid restriction order was limited to no water pitcher at bedside. RN 1 stated, she had been looking for a fluid restriction range since last week but could not find the range. During the same concurrent interview and record review on 2/12/2026 at 10:55 AM with RN 1, Resident 2's Nutritional Assessment RD dated 1/21/2026 was reviewed. RN 1 stated, Resident 2's fluid requirement indicated fluid limit to 750 - 1500mL. RN 1 stated, the fluid requirement meant this was Resident 2's fluid restriction range in 24-hours. RN 1 stated, she did not know this was the RD's recommendation. During the same concurrent interview and record review on 2/12/2026 at 11:05 AM with RN 1, Resident 2's electronic medical records (EMR) were reviewed. RN 1 stated, there was no place in the EMR to document the amount of fluids Resident 2 drank throughout the day and there was no documented evidence of monitoring Resident 2's fluid intake. RN 1 stated, since Resident 2 was receiving dialysis, it was important to monitor Resident 2's fluid intake to ensure she does not drink more than the fluid restriction range of 750 -1500mL. RN 1 stated the failure of not monitoring Resident 2's fluid intake may her experiencing fluid overload (excess fluid build-up in the body) that may result in swelling, high blood pressure crisis, heart failure, and shortness of breath leading to hospitalization. During a review of the facility's policy and procedure (P&P) titled Nutritional Assessment and Resident Care Plan Documentation, date unknown, the P&P indicated the nutritional assessment and resident care plan documentation will be provided for all residents and entered into the medical records. The P&P indicated the RD will include the estimation of the resident's nutritional intake and adequacy of nutritional intake.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure that Certified Nurse Assistant (CNA) 6 had the competency skill to accurately monitor and document one of one sampled residents (Resident 2) food intake who was receiving a renal diet (a specialized diet prescribed by the physicians for residents with kidney disorder) as indicated in the facility's policy and procedures. This failure had the potential to place Resident 2 at risk for unintended weight loss and fluid deficit or excess that could further decline in her nutritional management. Findings: During a review of Resident 2's admission Record (AR), the facility admitted Resident 2 on 12/27/2023 and readmitted Resident 2 on 1/16/2026 with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD, irreversible kidney failure), and hypothyroidism (thyroid does not make enough thyroid hormone to meet the body's needs). During a review of Resident 2's History and Physical (HP), dated 1/1/2026, the HP indicated that Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimal Data Set (MDS, a resident assessment), dated 1/20/2026, the MDS indicated that Resident 2's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident needed assistance (helper sets up or cleans up) for meals. The MDs indicated that Resident 2 was always incontinent (loss of control) of bladder and bowel. The MDS indicated that Resident 2 received hemodialysis and was on a therapeutic diet (diet prescribed by the physician). During a review of Resident 2's care plan, revised on 10/29/2024, the care plan indicated Resident 2 was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to DM. The care plan's interventions to offer snacks at bedtime and to monitor food intake and record. During a review of Resident 2's care plan, dated 1/24/2024, the care plan indicated Resident 2 was at risk for excessive weakness, shortness of breath, pale skin, or fatigue related to hypothyroidism. The care plan's interventions included to provide rest periods in between activities, observe for signs and symptoms of weakness or fatigue, and to monitor the percentage of Resident 2's intake and appetite. During a review of Resident 2's Active Order List, the order, dated 1/17/2026, indicated Resident 2's diet was placed on Renal 90 grams, Consistent Carbohydrate diet (CCHO diet, therapeutic diet focused on eating the same carbohydrates every day), regular texture and thin consistency. During a review of Resident 2's Nutritional - Amount Eaten (%) POC Response History record, the record indicated that on 2/11/2026 at 11:13 AM Resident 2 ate 60% of her breakfast and at 12:28 PM Resident 2 ate 60% of her lunch. During a concurrent observation and interview on 2/11/2026 at 8:28 AM with Certified Nurse Assistant (CNA) 4 in the hallway in front of Resident 2's room, Resident 2's breakfast tray was observed. CNA 4 stated Resident 2 did not eat her breakfast today and did not know Resident 2's fluid intake for breakfast. During a concurrent observation and interview on 2/11/2026 at 1:30 PM with Restorative Nurse Assistant (RNA) 2 in the hallway in front of Resident 2's room, Resident 2's lunch tray was observed. RNA 2 stated Resident 2 ate about 80% of her meal which consisted of eating most of her meats, a little bit of vegetables, and her desert, and drank about 3/4 of her cup of milk. During an interview on 2/11/2026 at 2:48 PM with CNA 6, CNA 6 stated, she picked up Resident 2's tray for breakfast the resident less than 50% of her meal. During an interview on 2/11/2026 at 2:48 PM with CNA 6 stated. she picked up Resident 2's trays and stated Resident 2 ate less than 50% of her breakfast tray and ate 50% of her lunch tray. During an interview on 2/12/2026 at 3:30 PM with the Director of Staff Development (DSD), the DSD stated that inaccurate monitoring and documentation of a resident's food intake may lead to weight loss, which is especially important to monitor in resident receiving dialysis. During the same interview and record review on 2/12/2026 at 3:44 PM, the facility's in-service sheet with the topic Nutritional and Hydration Needs dated 4/15/2025, was reviewed. The DSD stated CNA 4 and CNA 6 were not present April 2025 when Inservice about food intake documentation was done because they are newly hired. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Broadway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 West Broadway Glendale, CA 91204	
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures (P&P) titled In-service Training, all Staff, dated August 2022, the P&P indicated that the objective of in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to provide care and services to one of one sampled resident (Resident 8) with loss of dentures in accordance with facility policy and procedure titled Dental Services. This deficient practice had resulted in the Resident 8's ability to chew his food that could lead to choking or pain with chewing potentially leading to weight loss. Findings: During a review of Resident 8' face sheet, the face sheet indicated Resident 8 had an initial admission on [DATE] with the diagnoses but not limited to; major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , chronic ataxia (neurological sign characterized by impaired muscle coordination that leads to unsteady movements) and type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 10/11/2025, MDS indicated that Resident 8 needs supervision or touching assistance when performing oral hygiene and using dentures. During a review of Resident 8's inventory list of resident's clothing and possessions, dated 7/23/2025, the inventory list indicated that Resident 8 has upper and lower dentures signed and certified by the ADON. During an interview on 2/10/2026 at 11:28 AM with Resident 8's family member, family member stated that Resident 8 has no teeth and uses upper and lower dentures. During an interview on 2/11/2026 at 8:37 AM with Certified Nursing Assistant (CNA)6 in Resident 8's room, CNA 6 stated Resident 8's upper and lower dentures were not in his room and cannot find Resident 8's dentures. During an observation on 2/11/2026 at 12:30 PM in the dining room, Resident 8 was not using his upper and lower teeth denture while he was eating his lunch. During an interview on 2/12/2026 at 3:36 PM with the Assistant Director of Nursing (ADON), ADON stated Resident 8's inventory list, dated 7/23/2025 indicated that Resident 8 has upper and lower dentures. ADON stated that staff should have placed a resident identification label on Resident 8's dentures to help prevent from loss or misplacement. During a review of the facility's policy and procedure (P&P) titled, Dental Services, dated 3/2023 the P&P indicated, the facility will provide routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Dentures will be protected from loss or damage, to the extent practicable, while being stored. Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure complete and accurate medical records were complete and accurate for 2 of 8 sampled residents (Resident 64 and 42) by failure to ensure: Advance Directive (document used to verify and record that the resident or legal representative was informed of their rights to accept or refuse treatment) for Resident 64 was dated. Physician Orders for Life -Sustaining Treatment form (POLST- a physician's order that includes level of medical intervention) for Resident 42 contained required signature. This failure had the potential to result in confusion regarding the validity of resident's treatment preferences and delay or delivery of care that may not have been consistent with the residents wishes. Findings: During a review of Resident 64's admission Record indicated the facility admitted the resident originally on 09/07/2022, with a diagnosis of acute respiratory failure(lungs cannot get enough oxygen into the blood), kidney failure(kidneys cannot properly filter waste and excess fluid from the blood) and atrial fibrillation(an irregular fast heartbeat). During a review of Resident 64's History and Physical (H&P) dated 1/23/26, indicated Resident 64 has the capacity to understand and make decisions. During a review of Resident 64 Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 12/9/2025, indicated Resident 64 was cognitively (ability to think and reason). During a review of Resident 64's Advanced Directive Acknowledgement form dated 06/16/2025, the document lacked a date indicating resident is capable of making preferred intensity decisions. During a review of Resident 42's admission Record Indicated the facility admitted the resident on 1/28/2026, with a diagnosis of urinary tract infection (a bacteria in any part of the urinary system casing an infection) , adult failure to thrive(an adult becomes weak, loses weight, and declines physically and mentally without a single clear cause), and dysphagia(difficulty speaking or understanding language). During a review of Resident 42's History and physical (H&P) dated 1/30/2026, indicated this resident is able to make decisions for activities of daily living (ADL's). During a review of Resident 42's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 02/1/2026, indicated resident has moderate cognitive impairment (have difficulty recalling words, require cueing or reorientation and have impaired short - term memory). During a review of Resident 42's POLST dated 1/3/2025, the required signature of the resident of legally recognized decision - maker was not present. During a concurrent interview and record review on 2/10/2026 at 09:16AM with Director of Nursing (DON), Resident 64's Advance Directive Notification was reviewed. DON verified the Advance Directive Notification was incomplete and stated that a date should have been included to ensure the document was accurately completed. During a concurrent interview and record review on 2/10/2026 at 9:19AM with Registered Nurse (RN3), Resident 42's POST was reviewed. RN3 stated the POLST did not include a signature from the legally recognized decision maker. RN3 verified that the document was not signed and stated that the legal document should have been completed with the required signature to ensure it was valid. During a concurrent interview and record review on 2/11/2026 at 11:40AM with Social Service Director (SSD), Resident 64's Advance Directive Acknowledgment form and Resident 42's POLST were reviewed. The SSD confirmed that Resident 64's Advance Directive Acknowledgement Form did not include a date indication the resident' s decision - Making status at time of completion. Additionally, Resident 42's POLST was unsigned. The SSD stated it is her responsibility to ensure residents' POLST forms and advance directives are completed accurately and acknowledged that these findings were documentation errors. During a review of the facility's policy and procedures (P&P) titled Quick Reference Guide on POLST in Nursing Homes dated 05, 2024, indicated A POLST isn't valid unless it is signed by (1) a physician, nurse practitioner (NP) or physician's assistant (PA) and (2) the resident or, if the resident lacks capacity, the resident's legally recognized healthcare decision -maker. The POLST compliments a resident' s Advance Directive. If a resident has a POLST and an Advance Directive, the two documents should be (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consistent. When filling out POLST, staff should confirm whether the resident has an Advance Directive and, if so, obtain a copy of the Advance Directive and review it. During a review of the facility's policy and procedures (P&P) titled Advance Directives undated, indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance Directive is written instruction, such as a living will or durable power of attorney for health care. Nursing staff are responsible for documentation in the medical record		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's infection control program for one of eight sample residents (Resident 62) by failing to assess and document signs and symptoms of respiratory infection as indicated in the facility's policy and procedure titled Infection Control. This deficient practice placed other residents at risk of respiratory infection. Findings: During a record review of Resident 62's admission Record (AR) the AR indicated Resident 62 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), encephalopathy (malfunction of the brain that alters its structure or function), respiratory syncytial virus (RSV - a common, contagious virus causing mild, cold-like symptoms in most people but it can lead to severe lung infections like bronchiolitis or pneumonia in older adults). During a record review of Resident 62's Minimum Data Set (MDS - a resident assessment tool) dated 1/19/2026, indicated Resident 62 had severe cognitive (ability to think and reason) During a record review of Resident 62's History & Physical (H & P) dated 10/16/2025, indicated Resident 62 does not have the capacity to understand and make decisions. During a record review of Resident 62's Order Summary Report dated 2/1/2026 indicated, to monitor for signs and symptoms of Corona Virus Disease (COVID - a highly contagious respiratory illness caused by the SARS-CoV-2 virus, spreading mainly through airborne droplets from coughs, sneezes, or conversation) such as cough, shortness of breath, or difficulty breathing, fatigue, chills, muscle or body ache, sore throat, new loss of taste or smell, headache, congestion or runny nose, diarrhea, nausea/vomiting, and to document temperature, pulse and pulse oximetry every day shift. During a record review of Resident 62's Change of Condition/Interact Assessment Form, dated 2/9/2026 6:00 AM indicated Resident 62 had a suspected respiratory infection with symptoms of cough with a documented temperature of 98.0 Fahrenheit (F - a scale of temperature) and 98.0 F, pulse oximetry (SpO2 - oxygen in your blood) 95% and a heart rate (number of times your heart beats in one minute) of 69%. During a record review of Resident 62's Change of Condition/Interact Assessment Form, dated 2/10/2026 at 8:00 AM indicated Resident 62 currently on monitoring for coughing and new medication Azithromycin (antibiotic that treats bacteria) medication order given by physician. During a record review of Resident 62's Medication Administration Record, dated 2/9/2025 - 2/11/2026 indicated that there were no documented episodes of coughing. During an interview on 2/11/2026 at 11:09 AM Infection preventionist (IP- a person designated to serve as a coordinator of the infection prevention and control program). IP stated Resident 62 should have had a complete set of vital signs including a temperature, heart rate, and pulse oximetry following the recognition of the detected change of condition of coughing with the goal to prevent a potential outbreak of exposing other residents and staff of any respiratory infection including COVID. IP stated that it is important for primary caregivers to assess residents for signs of infection to prevent outbreaks. During an interview on 2/12/2026 at 2:01 PM with the Director of Nurses (DON) stated that a temperature should have been obtained followed by a change of condition since fever is a sign of infection. DON stated it is important to obtain a temperature reading with a new onset of cough to ensure an accurate report to the attending physician to ensure proper orders and plan of care are given by the attending physician. During a review of the facility's policy and procedure (P&P) titled, Infection Control, undated, indicated, that the facility must have an infection control program to be able to investigate, control, and prevent infections in the facility. The P&P indicated that infection prevention and control program includes monitoring and documenting infections.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident's bedrooms measured at least 80 square feet (sq. ft) per resident for 30 of 31 rooms (Rooms 1-4, 6-12, 4-32) in the facility in accordance with the facility's policies and procedures (P&P) titled, Bedrooms, dated May 2017. This deficient practice had the potential to negatively impact the care and services of the facility's staff and to provide safe nursing care and privacy to the residents. Findings: During a review of the facility's request for an additional room size waiver, dated 2/9/2026, the room waiver indicated that each bathroom was easily accessible in the rooms, and there was sufficient room between beds and the foot of the beds to allow freedom of movement and transfers for wheelchair-bound residents. During a review of the Client Accommodation Analysis form, dated 2/9/2026, submitted by the facility on 2/9/2026, the form indicated that there were 31 rooms that did not measure 80 sq. feet per resident as listed below: room [ROOM NUMBER]: Required sq. ft = 160 sq. ft; Actual sq. ft = 151.2 square feet with 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 144.88 sq.ft; 2 beds with 1 resident. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 134.88 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 156.76 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 184.28 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 159.18 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 141.47 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 149.54 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 141.47 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 141.64 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 314.27 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 3 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 144.42 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 144.51 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 144.54 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 320 sq. ft; Actual sq. ft = 291.48 sq.ft; 4 beds with 4 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 149.85 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 148.01 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 138.99 sq.ft; 2 beds with 1 resident. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 145.91 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 138.99 sq.ft; 2 beds with 2 residents. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 145.91 sq.ft; 2 beds with 1 resident. room [ROOM NUMBER]: Required sq. feet = 160 sq. ft; Actual sq. ft = 138.92 sq.ft; 2 beds with 2 residents. During the survey, multiple observations from 2/9/2026 to 2/12/2026 were conducted at random times from 8 AM to 5 PM. The (continued on next page)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	residents in Rooms 1-4, 6-12, and 4-32 were observed to have adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (a device that provides additional support to maintain balance or stability while walking), or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care for the residents. During an interview on 2/11/2026 at 3:55 PM in room [ROOM NUMBER], Residents 26, 53, 60 stated they were happy with the care at the facility, and they felt they had enough space in their rooms. Resident 26, 53, and 60 stated the nursing staff was able to provide care without difficulty. During an interview on 2/11/2026 at 4:01 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated that the space in resident rooms was adequate and denied that space was a barrier to resident care. CNA 1 stated there was enough room to provide activities of daily living (ADL, activities such as bathing, dressing, and toileting a person performs daily) care for the residents. CNA 1 stated, there has been no issue providing care in the rooms when there was an emergency or transferring the furthest resident from the door out of the room. During an interview on 2/11/2026 at 4:30 PM with Resident 58, Resident 58 stated the space of his room was not a barrier to the care provided by the facility. During an interview on 2/11/2026 at 4:05 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, there was no difficulty providing care to his residents in their rooms and if there was an emergency in the room, the trash cans and wheelchairs were moved out of the room and the residents' beds were shifted to the side to make room for the resident to be transferred out of the room. LVN 2 stated, once the resident has been transferred out of the room, the residents' beds, trash cans, and wheelchairs would be put back in place. During an interview on 2/11/2026 at 4:15 PM with CNA 2, CNA 2 stated there was adequate space to provide ADL cares to her residents in their rooms. During a review of the facility's policies and procedures (P&P) titled Bedrooms, dated May 2017, the P&P indicated that bedrooms measure at least 80 square feet of space per resident in double rooms.		