

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Broadway by the Sea		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. Broadway Long Beach, CA 90803	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028</p> <p>Based on interview and record review, the facility failed to ensure a Interdisciplinary ([IDT] Resident ' s health care team members from different specialties working together, with a common purpose, to set goals, make decisions that ensure residents receive the best care) Care Conference meeting following a readmission from a General Acute Care Hospital (GACH), involving one of six sampled residents (Resident 1) and their responsible party (RP), was held.</p> <p>This deficient practice violated Resident 1 and RP 1 ' s right to be an active participant in Resident 1 ' s plan of care and services with the IDT and delayed the discussion of needed care and services.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including epilepsy (a disorder of the brain characterized by repeat seizures [brief episodes of involuntary movement which may include a part of the body or the entire body]), lack of coordination (not able to move different parts of the body together well), need for assistance with personal care, unspecified dementia (the impaired ability to remember, think, or make decisions which interfere with doing everyday activities), and hemiplegia (total or partial paralysis [loss of the ability to move] of one side of the body) affecting the left nondominant (part of the body which is not used as much) side.</p> <p>During a review of Resident 1 ' s History and Physical (H&P), dated 1/16/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS]) a standardized assessment and care screening tool) dated 1/17/2024, the MDS indicated Resident 1 ' s cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 1 was totally dependent on staff for eating, personal hygiene, toileting, bathing, upper and lower body dressing and rolling left to right in bed.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation, dated 6/17/2023, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s untitled Care Plan, dated 6/17/2023, the Care Plan indicated Resident 1 had a risk for falls related to left sided weakness, unsteady gait/balance, generalized muscle weakness, and hypertension (high blood pressure). The Care Plan goal indicated Resident 1 would be free of falls through review date of 3/8/2024. The Care Plan interventions included for Resident 1 to have floor mats (high-impact foam pads which are placed adjacent to the bed on the floor to help reduce the impact of falls and help prevent injury from potential falls) at bedside.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation dated 10/24/2024 and timed at 9:52 p.m., the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk after sustaining a fall from the bed to the floor on 10/24/2024.</p> <p>During a review of Resident 1 ' s Fall Risk Evaluation dated 11/20/2024, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk after sustaining a second fall from the bed to the floor on 11/20/2024.</p> <p>During a review of Resident 1 ' s quarterly Fall Risk Evaluation dated 12/14/2023, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>During a review of Resident 1 ' s readmission Note dated 1/19/2024 and timed at 10:30 p.m., the readmission Note indicated Resident 1 was readmitted from a GACH due to syncope (fainting or passing out) during dialysis (a procedure to remove waste products and excess fluid from the blood when the organs which remove waste and extra water from the blood and keep chemicals balanced in the body stop working) on 1/17/2024.</p> <p>During a review of Resident 1 ' s readmission Fall Risk Evaluation dated 1/13/2024 the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>During an interview on 3/15/2024 at 11:45 a.m., with Resident 1 ' s Responsible Party (RP) 1, RP 1 stated after Resident 1 ' s second fall in 11/2023 she requested a bed alarm, fall mats, siderails, and bed bolsters (air filled raised pads placed at the edge of the bed to prevent residents from rolling out of the bed) implemented in Resident 1 ' s care. RP 1 stated in 2/2024, when Resident 1 ' s Family Member (FM) 2 went to visit Resident 1 in the facility, he noticed there was no fall mats, no bed alarm, nor siderails. RP 1 stated she brought this to the facility ' s attention and requested a care conference meeting to be held due to concerns regarding Resident 1 ' s care, but a meeting was never held nor were her requested interventions implemented.</p> <p>During a review of Resident 1 ' s medical records, the medical records indicated an IDT Care Conference Note, dated 12/26/2023, the IDT Care Conference Notes indicated there was an IDT Care Conference conducted for Resident 1. Resident 1 ' s medical records did not indicate any more IDT Care Conferences were conducted for Resident 1 since the one conducted on 12/26/2023.</p> <p>During a review of Resident 1 ' s Social Service Progress Notes, dated 1/19/2024 to 3/5/2024, the Social Service Progress Notes did not indicate Resident 1 ' s RP was contacted to schedule an IDT Care Conference Meeting.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/2024 at 11:38 a.m., with the Social Services Director (SSD), the SSD stated when a resident is readmitted from a GACH, an IDT Care Conference meeting should be done within seven days of admission or readmission. The SSD stated the purpose of the IDT Care Conference meeting is to address questions, concerns, and to go over the resident ' s care plan (CP) to ensure the CP was appropriate for that specific resident. The SSD stated prior to her coming to the facility, there were issues with missed IDT Care Conference meetings, but she is currently working on fixing the issues. The SSD stated Resident 1 should have had an IDT Care Conference meeting within the seven days of readmission to the facility.</p> <p>During a review of the facility ' s policy and procedure (P/P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, indicated it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered (to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives) CP for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P/P indicated the facility team will provide a written summary of the baseline CP to the resident and their representative that includes the initial goals of the resident, a summary of medications and dietary instructions, and any services and treatments to be administered. The P/P indicated the summary will be in a language and conveyed in a matter the resident and/or their representative can understand, and the summary will be provided by the time of the completion of the comprehensive care plan.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028</p> <p>Based on interview and record review the facility failed to ensure a resident, who had physician ' s treatment orders for skin scratches, received the treatment for the scratches, for one of eight sampled residents (Resident 5).</p> <p>This deficient practice resulted in Resident 5 not receiving the treatment as ordered and had a potential for Resident 1 to have further decline in skin integrity due to not receiving the ordered treatment.</p> <p>Findings:</p> <p>During a review of Resident 5 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of ovary (a type of cancer [disease of the cells (provide structure for the body, take in nutrients from food, convert those nutrients into energy, and carry out specialized functions) in the body] which begins in the ovaries [one of a pair of female reproductive glands in which the eggs are formed]), weakness, and aphasia (inability to communicate with others) with Hospice (medical care that focuses on the Resident ' s quality of life as they near the end of life).</p> <p>During a review of Resident 5 ' s History and Physical (H&P) dated 1/20/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 5 ' s Minimum Data Set ([MDS] a standardized assessment and care planning tool) dated 1/26/2024, the MDS indicated Resident 5 was rarely understood and could rarely understand others. The MDS indicated Resident 5 ' s cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 5 was totally dependent on staff for eating, oral hygiene, toileting, bathing, upper and lower body dressing, personal hygiene, and chair/bed to chair transfer. The MDS indicated Resident 5 required substantial/maximum assistance from staff for rolling left to right, sit to lying in bed, and lying to sitting on the side of the bed. The MDS indicated Resident 5 was incontinent (inability to control the excretion of urine or the contents of the bowels [stool]) of urine and stool.</p> <p>During a phone interview on 3/13/2024 at 11:38 a.m., with Resident 5 ' s Responsible Party (RP) 1, RP 1 stated on 2/27/2024 she noticed Resident 5 had scratches on her left buttocks and left abdomen which she had reported to the hospice Licensed Vocational Nurse (LVN 5) during her visit on 2/27/2024.</p> <p>During a review of Resident 5 ' s Plan of Care Summary (Hospice Orders), the Plan of Care Summary indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 2/27/2024, an order was placed to cleanse scattered scratches on Resident 5 ' s left buttocks with normal saline (cleansing solution), pat dry and apply triple antibiotic ointment (medication used to treat minor skin infections [the invasion and growth of germs in the body]). The Treatment Orders indicated to treat daily and/or as needed for soiling (when clothing or bed linens come into contact with urine or stool). The Treatment Orders indicated for the hospice nurse to provide care once a week and facility staff to provide the treatment at all other times. The Treatment Orders indicated to reassess Resident 5 ' s skin in 14 days.</p> <p>2. On 2/27/2024, an order was placed to cleanse Resident 5 ' s left abdominal (belly) scratch with normal saline, pat dry, and apply triple antibiotic ointment. The Treatment Orders indicated to treat daily and/or as needed for soiling. Hospice nurse to provide care once a week and facility staff to provide treatment at all other times. Reassess Resident 5 ' s skin in 14 days.</p> <p>During a review of Resident 5 ' s Treatment Administration Records dated for the month of 2/2024 and the month of 3/2024, the Treatment Administration Records indicated there were no treatments provided to Resident 5 ' s skin scratches.</p> <p>During an interview on 3/13/2024 at 3:53 p.m., with the Treatment Nurse (TN) 1, TN 1 stated she was not aware of Resident 5 ' s new treatment orders.</p> <p>During an interview on 3/15/2024 at 4:02 p.m., with the hospice Registered Nurse (RN) 3, RN 3 indicated on 2/27/2024 LVN 5 notified her of the scratches found on Resident 5 ' s skin. RN 3 stated LVN 5 informed LVN 4 of the scratches noted on Resident 5 ' s skin and treatment orders would be sent to the facility.</p> <p>During an interview on 3/15/2024 at 4:35 p.m., LVN 4 stated the facility follows all orders received from the hospice physician. LVN 4 stated the hospice orders are usually faxed to the facility which is then reviewed by the licensed nurses or RN supervisor and transcribed in the resident ' s electronic health record. LVN 4 stated LVN 5 informed her of Resident 5 ' s scratches and that treatment orders would be sent to the facility. LVN 4 stated she did not assess Resident 5 ' s skin after speaking to LVN 5 nor did she follow-up to check to see if new orders were sent for Resident 5.</p> <p>During an interview on 3/16/2024 at 3:41 p.m., with TN 2, TN 2 stated she was not aware of Resident 5 ' s new treatment orders.</p> <p>During an interview on 3/18/2024 at 2:40 p.m., with the Assistant Director of Nursing (ADON), the ADON stated it is the responsibility of the licensed nurses to transcribe all physician ' s orders once they are received. The ADON stated it is the responsibility of the licensed nurses to ensure all orders are carried out. The ADON stated if the nurses don ' t transcribe the orders as they are received then residents don ' t receive the necessary care.</p> <p>During a review of the facility ' s LVN Job Description, dated 12/17/2021, indicated the essential duties and responsibilities and responsibilities of the LVN include preparing and administering medications as ordered by the physician.</p> <p>During a review of the facility ' s policy and procedure (P/P) titled, Physician Orders, revised 5/2007, indicated the charge nurse or the Director of Nursing (DON) shall place the order for all prescribed medications.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P/P titled, Skin and Wound Monitoring and Management, revised 12/2023, indicated once an area of alteration in skin integrity has been identified .nursing shall administer treatment to each affected area as per the Physician ' s Order.		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028</p> <p>Based on observation, interview and record review, the facility failed to ensure the residents, who were assessed as a high risk for falls, had preventative measures implemented to prevent them from falls and injuries for three out of eight sampled residents (Residents 1, 3, and 4). The facility failed to:</p> <ol style="list-style-type: none"> 1. Implement interventions including landing mats and bed alarm for Resident 1 as care planned Resident 1 had a history of falls on 10/24/2023 and 11/20/2024 and was assessed as a high fall risk. 2. Ensure Licensed Vocational Nurse (LVN 1) had knowledge of Resident 1's high risk for fall, how to access Resident 1' Care Plans, to implement interventions to safeguard Resident 1 from falls and injuries, and knowledge of facility's protocol for falls. 3. Implement bed in the lowest position for Resident 3, who had a history of seizures (brief episodes of involuntary movement which may include a part of the body or the entire body) as care planned. Resident 3 was assessed as a high fall risk. 4. Implement Resident 4's bed in the lowest position. Resident 4 was assessed as a high fall risk. 5. Ensure the facility has a protocol in place for facility staff to identify high fall risk residents and implement resident specific fall prevention measures for the residents who are identified as a high fall risk. 6. Ensure the licensed nurses (LNs) followed the facility's policy and procedure (P&P) titled, Fall Management System, by implementing individualized care plan interventions for residents who were identified as a high fall risk. 7. Ensure the licensed nurses discussed the residents who were at risk for falls at the daily huddle meetings and upon shift report and were responsible for relaying the information to the care team. 8. Ensure the licensed nurses were implementing resident centered Care Plan with interventions based on the resident's fall risk assessment. <p>These failures resulted in:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A. Resident 1 falling from the bed to the floor on 3/4/2024, vomiting (an act of throwing up the contents of the stomach through the mouth) and having an altered level of consciousness (a change in a person's state of awareness [ability to relate to self and the environment] and arousal [alertness]) on 3/5/2024. Resident 1 was transferred to a general acute care hospital (GACH) on 3/5/2024 and subsequently admitted to the Intensive Care Unit (ICU) an area in the hospital which handles severe, potentially life-threatening cases) with diagnoses including with head trauma (any injury to the scalp, skull, or brain caused by injury), abrasion (a superficial rub or wearing off of the skin) to the right forehead, intracranial (within the skull) hemorrhage (bleeding) with thick subdural hematoma ([SDH] a collection of blood between the covering of the brain and the surface of the brain which develops after an injury to the head) over the right cerebral hemisphere (the part of the brain that controls muscle functions and also controls speech, thought, emotions, reading, writing, and learning) secondary to fall. Resident 1 required immediate endotracheal ([ET] placed within the trachea [windpipe]) intubation (a medical procedure in which a tube is placed into the windpipe through the mouth or nose to assist breathing), emergent right temporal (area of the brain located behind the ears) parietal (area of the brain at the top rear of the head) craniotomy (a medical procedure in which a piece of bone from the skull is removed to access the brain for surgical repair) and subdural hematoma evacuation (a surgical procedure which is done to remove a pooling of blood in the brain) with subdural drainage placement due to a high probability of clinically significant, life-threatening deterioration. While in ICU Resident 1 later required a tracheostomy (a surgically created hole in the windpipe which provides an alternative airway for breathing) due to a total dependence on ventilator (a machine used to help a person breathe when they can no longer breathe on their own) for breathing and gastrostomy tube ([GT] a tube which is inserted through the wall of the abdomen directly into the stomach which is used to give medications, fluid, and liquid food to a patient) for nutrition and medication administration.</p> <p>B. Residents 3's and Resident 4's care plans for fall with interventions to prevent falls and injuries were not being resident-centered and not implemented thus placing these residents at risk for injury resulting from a fall.</p> <p>On 3/19/2024 at 2:13 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation caused, or was likely to cause serious injury, harm, impairment, or death to a resident) related to the lack of a system in place to indicate what specific fall prevention measures nursing staff must utilize and implement for the residents who are identified as a high fall risk was called in the presence of the Administrator (ADM) and Assistant Director of Nursing (ADON).</p> <p>On 3/20/2024 at 3:53 p.m., the facility submitted an acceptable IJ removal plan ([IJRP] an intervention to immediately correct the deficient practices). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed on 3/20/2024 at 4:25 p.m., in the presence of the ADM, ADON and Registered Nurse Clinical Resource (RNCR) 1.</p> <p>The IJRP included the following:</p> <ol style="list-style-type: none"> 1. Resident 1 was transferred to the hospital on 3/12/2024 and has not returned to the facility. 2. Resident 3 was re-evaluated by a licensed nurse on 3/19/2024 and identified to be at high risk for falls. On 3/20/2024, the IDT started reviewing and updating the care plan interventions based on Resident 3's individual risk factors. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Resident 4 was re-evaluated by a licensed nurse on 3/19/2024 and identified to be at high risk for falls. On 3/20/2024, the IDT started reviewing and updating care plan interventions based on Resident 4's individual risk factors.</p> <p>4. On 3/19/2024, the facility IDT implemented a Falling Star Program to communicate high fall risk residents to the facility staff.</p> <p>5. The Director of Staff Development (DSD), ADON, and RNCR 1 initiated licensed nurses in-services (staff education sessions) regarding the evaluation of residents' fall risk upon admission, readmission, with every fall and as needed.</p> <p>6. The DSD, ADON, and RNCR 1 initiated all Certified Nursing Assistants (CNAs) in-services regarding the Falling Star Program.</p> <p>7. The DSD, ADON, and RNCR 1 initiated in-services with all facility staff regarding the updated Fall Management Policy, the Falling Star Program for high risk for fall residents, and the Special Needs List.</p> <p>8. On 3/19/2024 and 3/20/2024, the ADON, the Minimum Data Set ([MDS] a standardized assessment and care planning tool) Nurse ([MDSN] long-term nurses specializing in assessing the needs of long-term care residents), the Unit Manager (UM), RNCR 1, and the Infection Prevention Nurse (IP) re-evaluated all residents (84 total) for their fall risk and documented this in the Licensed Nurse-Fall Risk Evaluation. These were reviewed by RNCR 1. 32 residents were identified to be at high risk for falls and were added to the Falling Star Program. Their fall risk interventions were added to the Special Needs List for staff reference and this list will be updated daily, Monday through Friday, by the DSD. The Special Needs List will include residents' individual fall interventions and will be available in the nursing stations for reference.</p> <p>9. On 3/19/2024, the DSD, ADON, RNCR 1 and Therapy Program Manager reviewed and updated the Special Needs List to include all current residents, their fall risk, and fall interventions. This list will be updated daily Monday through Friday by the DSD. The Special Needs List will include residents' individual fall interventions and will be available in the nursing stations for reference.</p> <p>10. Person centered CPs developed interventions were added to the CPs specific to resident's identified as high fall risk.</p> <p>11. The Fall Committee (including ADON, Director of Rehabilitation [DOR], DSD, Maintenance Director, Social Services, Activities, and CNA Designee) will review all high-risk residents in the Falling Star Program weekly to ensure their interventions are resident-centered and appropriate.</p> <p>Findings: (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including epilepsy (a disorder of the brain characterized by repeat seizures, lack of coordination (not able to move different parts of the body together with intention), need for assistance with personal care, unspecified dementia (the impaired ability to remember, think, or make decisions which interfere with doing everyday activities), and hemiplegia (total or partial loss of the ability to move one side of the body) affecting the left nondominant (part of the body which is not used as much) side.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 1/16/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognitive (a person's ability to think, learn, remember, use judgement, and make decisions skills for daily living) skills for daily decision making were severely impaired. The MDS indicated Resident 1 was totally dependent on staff for eating, personal hygiene, toileting, bathing, upper and lower body dressing and rolling left to right in bed.</p> <p>During a review of Resident 1's Fall Risk Evaluation, dated 6/17/2023, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>During a review of Resident 1's untitled Care Plan, initiated on 6/17/2023, the Care Plan indicated Resident 1 was identified to be at risk for falls related to left sided weakness, unsteady gait (manner of walking) /balance, generalized muscle weakness, and hypertension (high blood pressure). The Care Plan goal indicated Resident 1 would be free of falls through review date of 3/8/2024. The Care Plan interventions for Resident 1 included to have landing mats (high-impact foam pads which are placed adjacent to the bed on the floor to help reduce the impact of falls and help prevent injury from potential falls) at bedside.</p> <p>During a review of Resident 1's Fall Risk Evaluation dated 10/24/2023 and timed at 9:52 p.m., the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk after sustaining a fall from the bed to the floor on 10/24/2023.</p> <p>During a review of Resident 1's Fall Risk Evaluation dated 11/20/2023, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk after sustaining a second fall from the bed to the floor on 11/20/2023.</p> <p>During a review of Resident 1's untitled Care Plan dated 11/22/2023, the Care Plan indicated Resident 1 utilizes bed and wheelchair alarm to alert staff and resident when he gets up unassisted. The Care Plan goal indicated Resident 1 will remain free of complications related to alarm use through review date of 3/8/2024. The Care Plan interventions included to apply a sensor pad (a weight sensitive alarm device) as ordered.</p> <p>During a review of Resident 1's quarterly Fall Risk Evaluation dated 12/14/2023, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Readmission Note dated 1/19/2024 and timed at 10:30 p.m., the Readmission Note indicated Resident 1 was readmitted from a GACH where he had been transferred to on 1/17/2024 due to syncope (fainting or passing out) during hemodialysis (a mechanical procedure to remove waste products and excess fluid from the blood when the kidneys [a pair of organs which remove waste and extra water from the blood and keep chemicals balanced in the body] stop working).</p> <p>During a review of Resident 1's readmission Fall Risk Evaluation dated 1/13/2024, the Fall Risk Evaluation indicated Resident 1 was assessed as a high fall risk.</p> <p>During a review of Resident 1's Change of Condition ([COC] a document indicating a deterioration or improvement in a resident's physical or behavioral health which may require a modification in the resident's treatment) dated 3/4/2024 and timed at 8:09 p.m., the COC indicated Resident 1 had an unwitnessed fall from the bed to the floor. The COC indicated Resident 1 sustained redness to the right side of his forehead. The COC indicated to initiate neurological check (identifying and assessing the functions of the vital portions of the central nervous system [transmits signals between the brain and the rest of the body which controls the ability to move, breathe, think, and see] functioning) for 72 hours.</p> <p>During a review of Resident 1's COC dated 3/5/2024 and timed at 2:34 a.m., the COC indicated Resident 1 was vomiting and had ALOC. The COC indicated Resident 1 was awake and alert but unable to maintain eye contact or verbalize his needs.</p> <p>During a review of Resident 1's Incident Report (a documentation tool used by emergency medical responders ([EMRs] provide immediate lifesaving care to critical patients who are not in the hospital) to record patient data when arriving on the scene) dated 3/5/2024, the Incident Report indicated Emergency Medical Services ([EMS] a system which provides emergency medical care) were called to the SNF. The Incident Report indicated Resident 1's level of consciousness (being awake and aware of surroundings) was an 11 based on the Glasgow Coma Scale ([GCS] clinical scale used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients which is scored between 3 and 15, with 3 being the worst and 15 the best). The Incident Report indicated Resident 1 was found with an abrasion to the right temple area. On 3/5/2024 Resident 1 was subsequently transported to a GACH due to ALOC and traumatic injury (physical injuries of sudden onset and severity which require immediate medical attention)</p> <p>During a review of Resident 1's GACH Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the GACH on 3/5/2024 under trauma services (a hospital equipped and staffed to provide care for patients suffering from major traumatic injuries such as falls, motor vehicle collisions, or gunshot wounds).</p> <p>During a review of Resident 1's GACH Trauma/Resuscitation Flowsheet dated 3/5/2024 and timed at 3:31 a. m., the Trauma/Resuscitation Flowsheet indicated Resident 1 had an abrasion and a hematoma to the right forehead.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Physician's Emergency Documentation dated 3/5/2024 and timed at 3:42 a. m., the Physician's Emergency Documentation indicated Resident 1 was brought in by EMS from SNF after an unwitnessed fall with evidence of head trauma and activated as a trauma alert. The Physician's Emergency Documentation indicated Resident 1 normally had a GCS of 13 and presented to the GACH with a GCS of 11. The Physician's Emergency Documentation indicated Resident 1 presented in critical condition, with concern for acute decompensation (failure of an organ) and possible cardiopulmonary arrest (sudden, unexpected loss of heart function, breathing and consciousness).</p> <p>During a review of Resident 1's Computed Tomography ([CT] a procedure which uses a computer linked to an x-ray an imaging study which takes pictures of bones and soft tissue) machine to make a series of detailed pictures of areas inside the body) scan dated 3/5/2024 and timed at 4:04 a.m., the CT scan indicated Resident 1 had a 1.7 centimeter ([cm] a measure unit of length) thick acute subdural hematoma over the right cerebral hemisphere and a 1.1 cm midline shift (when the natural centerline of the brain is pushed to the to the right or left following traumatic brain injury associated with a hematoma) from right to left.</p> <p>During a review of Resident 1's GACH Neurosurgery Operative and Procedural Report dated 3/5/2024 and timed at 8 a.m., the Neurosurgery Operative and Procedural Report indicated Resident 1 underwent a right sided frontotemporal (the areas behind the forehead and behind the ears) craniotomy for evacuation of acute subdural hematoma and resection (surgery to remove tissue or part or all of an organ) of membranes (layer which protect the brain), and externalized drain placement (tube which drains excess fluid or blood from the brain and stops the fluid building up). The Neurosurgery Operative and Procedural Report indicated Resident 1 was then transferred to the ICU post-operatively.</p> <p>During a review of Resident 1's GACH Operative and Procedure Report dated 3/13/2024 and timed at 1:16 p. m., the Operative and Procedure Report indicated Resident 1 underwent a GT insertion due to oropharyngeal (the middle part of the throat behind the mouth) dysphagia (difficulty swallowing) and tracheostomy due to acute respiratory failure (not enough oxygen in the body to sustain life) requiring long term mechanical ventilation.</p> <p>During an interview on 3/14/2024 at 4:37 p.m., Registered Nurse (RN 1) stated on 3/4/2024, the Licensed Vocational Nurse (LVN 1) informed her of Resident 1's fall from the bed to the floor. RN 1 stated when she went to assess Resident 1 after the fall, there were no landing mats noted on the floor. RN 1 stated because of Resident 1's high risk for fall and history of previous falls, there should have been landing mats on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/14/2024 at 5:34 p.m., LVN 1 stated she was assigned to Resident 1 on 3/4/2024. LVN 1 stated at around 8 p.m., she was informed by Certified Nurse Assistant (CNA) 1 of Resident 1's fall from the bed to the floor. LVN 1 stated upon arrival to Resident 1's room, she found Resident 1 on the floor. LVN 1 stated Resident 1 was on the bare floor and there were no landing pads underneath him, nor were there any or bed alarm. LVN 1 stated she was not aware of Resident 1's Care Plan and interventions which included bed alarm, and landing mats. LVN 1 stated it was her second day working on the unit and was not aware on how to access residents' Care Plans. LVN 1 stated she was not aware that Resident 1 was a high risk for falls because the outgoing nurse did not report it to her during shift report, and it was not mentioned during the huddle at the beginning of the shift. LVN 1 stated she was not aware of what interventions should be implemented for residents who are a high fall risk. LVN 1 stated she should have looked at Resident 1's Care Plan prior to assuming care of Resident 1 since she was not familiar with the resident. LVN 1 stated the purpose of a Care Plan is to prevent accidents and incidents from occurring or reoccurring. LVN 1 stated she does not know what the facility's protocol for falls and fall prevention.</p> <p>During an interview on 3/14/2024 at 6:22 p.m., CNA 1 stated on 3/4/2024 at around 8 p.m., she was walking by Resident 1's room and saw Resident 1 laying on the bare floor. CNA 1 stated she did not see any landing mats underneath Resident 1, nor did she hear a bed alarm going off.</p> <p>During an interview on 3/15/2024 at 11:45 a.m., Resident 1's Responsible Party (RP 1) stated on 3/4/2024 at approximately 8:52 p.m., she received a call from the SNF indicating Resident 1 had an unwitnessed fall from the bed to the floor. RP 1 stated in the early morning of 3/5/2024 she received a second call from the SNF indicating Resident 1 vomited and had ALOC which required the resident's transfer to the GACH. RP 1 stated this was Resident 1's third fall since 10/2023. RP 1 stated after Resident 1's second fall in 11/2023 she requested a bed alarm, landing mats, two siderails up, and bed bolsters (air filled raised pads placed at the edge of the bed to prevent residents from rolling out of the bed) implemented in Resident 1's care. RP 1 stated in 2/2024, when (Family Member) FM 2 went to visit Resident 1 in the facility, he noticed there was no landing mats, no bed alarm, nor siderails. RP 1 stated she brought this to the facility's attention, but her requested interventions were never implemented.</p> <p>During an interview on 3/16/2024 at 3:16 p.m., CNA 2 stated on 3/4/2024 she was assigned to Resident 1 but did not witness the fall. CNA 2 stated she was not aware that Resident 1 was a high fall risk or what interventions to implement if a resident is a high fall risk. CNA 2 stated Resident 1 did not have landing mats or a bed alarm when she cared for him on 3/4/2024.</p> <p>During an interview on 3/13/2024 at 2:11 p.m., the ADON stated the facility does not currently have a program in place to prevent falls. The ADON stated the facility does not use special identifiers in the resident's room to identify those residents who are a high risk for falls. The ADON stated the facility has a Special Needs binder located at each nursing station which identifies the residents who are a high fall risk with interventions to prevent the residents from falls. The ADON stated the licensed nurses are responsible for knowing the resident's fall risk assessment and Care Plan interventions while caring for the resident. The ADON stated the licensed nurses should discuss the residents who are at risk for falls at the daily huddle meetings and upon shift report and are responsible for relaying the information to the care team. The ADON stated the licensed nurses are responsible for implementing resident's centered Care Plan with interventions based on the fall risk assessment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2024 at 3:36 p.m., CNA 4 stated she does not know how to identify residents who are assessed at high risk for falls other than asking the licensed nurses. CNA 4 stated residents who are a high fall risk are not mentioned during the huddle meetings.</p> <p>During an interview on 3/18/2024 at 3:38 p.m., LVN 2 stated the MDSN reviews and updates the care plans as needed. LVN 2 stated she can input information on the CPs if the resident has a change of condition but does not have time to review each resident's individual CP prior to caring for the resident because of all the other tasks she must complete throughout her shift. LVN 2 stated the purpose of a CP is to help the care team provide care for each resident individually and help prevent incidents and accidents from occurring and reoccurring. LVN 2 stated if we do not review the CPs then we (licensed nurses) do not know what interventions need to be implemented for each resident and communicated to the care team. LVN 2 stated she was not aware of the facility's fall protocol.</p> <p>B. During a review of Resident 3's Face Sheet, the Face Sheet indicated Resident 3 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including history of seizures, hemiplegia and hemiparesis affecting right dominant side, lack of coordination, and muscle weakness.</p> <p>During a review of Resident 3's H&P, dated 2/29/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was sometimes understood and sometimes was able to understand others. The MDS indicated Resident 3 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 3 was totally dependent on staff for toileting, showering, lower body dressing, sitting to lying, lying to sitting on the side of the bed, chair/bed to chair transfer, and toilet transfer. The MDS indicated Resident 3 required substantial/maximal assistance from staff for oral hygiene, upper body dressing, personal hygiene, and rolling left to right in bed. The MDS indicated Resident 3 had bilateral (both sides) upper body impairment and lower extremity impairment on one side.</p> <p>During a review of Resident 3's Readmission Note dated 1/25/2024 and timed at 11:59 p.m., the Readmission Note indicated Resident 3 was readmitted to the SNF from a GACH (where he had been transferred to on 1/20/2024 due to seizures.)</p> <p>During a review of Resident 3's readmission Fall Risk Evaluation, dated 1/25/2024, the Fall Risk Evaluation indicated Resident 3 was assessed as a high fall risk.</p> <p>During a review of Resident 3's untitled Care Plan, dated 3/1/2024, the Care Plan indicated Resident 3 had a risk for falls related to generalized muscle weakness, unsteady gait/balance, and seizure disorder. The Care Plan goal indicated Resident 3 would be free from falls through the target date of 4/25/2024. The Care Plan interventions included bed in lowest position.</p> <p>During a concurrent observation and interview on 3/18/2024 at 4:09 p.m., with CNA 5, in Resident 3's room, Resident 3 was observed lying in bed. CNA 5 stated the only way she identifies the residents at high fall risk if the residents' beds are low. CNA 5 stated Resident 3 was not a fall risk because the bed was not at the lowest position.</p> <p>During a review of Nursing Station 1's Special Needs Binder on 3/18/2024, Resident 3 was not found on the Special Needs List as a high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>C. During a review of Resident 4's Face Sheet, the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side, aphasia (inability to communicate with others), functional quadriplegia (complete immobility due to severe physical disability or frailty), vascular (affecting blood vessels) dementia, muscle weakness, and abnormal posture.</p> <p>During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was sometimes understood and was sometimes able to understand others. The MDS indicated Resident 4's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 4 had functional impairment in one upper extremity and had bilateral functional impairment in both lower extremities. The MDS indicated Resident 4 was totally dependent on staff for toileting, bathing, lower body dressing, sit to lying, sit to stand and chair/bed to chair transfers. The MDS indicated Resident 4 required substantial/maximum assistance from staff for rolling left to right in bed, upper body dressing, personal hygiene, and required supervision from staff for eating. The MDS indicated Resident 4 was incontinent of urine and stool. The MDS indicated Resident 4 used a wheelchair for mobility.</p> <p>During a review of Resident 4's untitled Care Plan dated 5/3/2023, the Care Plan indicated Resident 4 was at risk for falls related to functional quadriplegia, dementia, and incontinence. The Care Plan goal indicated Resident 4 would be free from falls though the review date of 3/7/2024. The CPs interventions included bed in lowest position and follow facility fall protocol (no specific person-centered fall interventions were documented on the Care Plan.)</p> <p>During a review of Resident 4's quarterly Fall Risk Evaluations dated 10/6/2023, and 1/18/2024 the Fall Risk Evaluations indicated Resident 4 was assessed as a high fall risk.</p> <p>During a concurrent observation and interview with CNA 5 on 3/18/2024 at 3:09 p.m., in Resident 4's room, Resident 4 was observed lying in bed watching TV. Resident 4's bed was observed to be not in lowest position. CNA 5 stated Resident 4's bed was not in the lowest position. CNA 5 stated Resident 4 did not require landing mats because she was not a high fall risk (CNA 5 was not aware Resident 4 was a high fall risk).</p> <p>During a review of Nursing Station 1's Special Needs List on 3/18/2024, the Special Needs List indicated Resident 4's special needs (fall precaution interventions) included bed at the lowest position for safety and bilateral landing pads on the side of the bed for safety while Resident 4 was in bed.</p> <p>During an interview on 3/19/2024 at 11:06 a.m., LVN 3 stated the only way she knows to check if a resident is a high fall risk is by checking the Special Needs Binder at each nursing station. LVN 3 stated if a resident is not listed on the Special Needs Binder, then they must not be a high risk for falls. LVN 3 stated she does not know what interventions are to be put in place for a resident based on the level of the fall risk (low, medium, high). LVN 3 stated she was not aware of the facility's fall protocol.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/2024 at 12:33 p.m., the DSD stated the licensed nurses should verbally communicate with each other about the residents who are a fall risk and what interventions should be implemented, during the change of shift and during the huddle. The DSD stated the licensed nurses can also refer to the Special Needs Binder at each nursing station to help them identify which level of fall risk each resident is and what interventions are required. The DSD stated the facility staff is responsible for updating the Special Needs Binder as needed.</p> <p>During an interview on 3/19/2024 at 1:36 p.m., the ADON stated there is a systemic problem regarding communication between the care team about the residents who are a high risk for falls, what Care Plan interventions are to be implemented based on their needs and implementing their Care Plan interventions for each resident. The ADON stated we educate the staff on how to identify those residents who are a high fall risk and what Care Plan interventions need to be implemented based on their needs, but it is up to the staff to follow through and apply the interventions to the residents.</p> <p>During a review of the facility's LVN Job Description dated 12/17/2021, the LVN Job Description indicated essential duties of the LVN include examining the resident and his/her records and charts, implementing, and maintaining established policies and procedures, and assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident are performed in furtherance of the resident care planning policy.</p> <p>During a review of the facility's ADON Job Description dated 12/17/2021, the ADON Job Description indicated the essential duties of the ADON include assisting in the development of preliminary and comprehensive assessments of the nursing needs of each resident are performed in furtherance of the resident care planning policy.</p> <p>During a review of the facility's P&P titled, Fall Management System, revised 12/2023, the P&P indicated it is the policy of this facility to provide an environment that remains as free from accident hazards as possible. The P&P indicated it is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The P&P indicated residents with high risk factors identified on the Fall Risk Evaluation will have an individualized Care Plan developed that includes measurable objectives and timeframes. The P&P indicated the Care Plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk.</p> <p>During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered (to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives) Care Plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>45028</p> <p>Based on observation, interview, and record review the facility's Quality Assessment and Assurance ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to identify facility and resident care issues, develop and implement appropriate plans of action to ensure the QAA/QAPI committee systematically implemented and evaluated measures to monitor, review, and analyze data for performance improvement facility issues such as implementing a fall prevention program, that facility staff are educated on, designed to prevent injury from falls, to help prevent the reoccurrence of falls and include person-centered interventions for residents who had a history of falls and/or are assessed as a high fall risk.</p> <p>This deficient practice had the potential to affect all 21 residents who were assessed as a high fall risk and had the potential not to systematically identify and implement fall risk precautions for each resident as needed.</p> <p>Findings:</p> <p>During a review of the facility ' s List of Fall Incidents, dated 1/1/2024 to 1/31/2024, the List of Fall Incidents indicated there were a total of four fall incidents within 30 days.</p> <p>During a review of the facility ' s List of Fall Incidents, dated 2/1/2024 to 2/29/2024, the List of Fall Incidents indicated there were a total of three fall incidents, with one resident falling twice during the month of 2/2024.</p> <p>During a review of the facility ' s List of Fall Incidents, dated 3/1/2024 to 3/14/2024, the List of Fall Incidents indicated there were a total of eight fall incidents, with two residents falling twice during the month of 3/2024.</p> <p>During a review of the facility ' s QAA/QAPI Meeting Minutes, dated 2/28/2024, the QAA/QAPI Meeting Minutes indicated falls were not identified and addressed as a current issue in the current QAPI.</p> <p>During an interview on 3/20/2024 at 1:15 p.m., with the Administrator, the Administrator stated the facility does address the facility ' s falls, however it is not a current issue that is addressed in the QAPI. The ADM stated the facility compares the number of fall incidents in the facility which is then compared to the surrounding facilities. The ADM stated based on the current facility number of falls and other facility ' s numbers of falls, our numbers were a lot lower than theirs, so we determined it was not a current issue that needed to be addressed in the QAPI.</p> <p>(continued on next page)</p>		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P/P) titled, Quality Assurance and Performance Improvement, revised 1/2022, indicated the purpose of the QAPI Plan and process is to continually assess the facility ' s performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual ' s highest practicable physical, mental, and social well-being.		