

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 06/18/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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 all items on the inventory list for one of three sampled residents (Resident 1) was accounted for when the facility failed to review and sign Resident 1's Inventory List with Resident 1's Power of Attorney ([POA] legal authorization for a designated person to make decisions about another person's property, finances, or medical care), following Resident 1's discharge from the facility on 3/12/2024.</p> <p>This deficient practice resulted in the inability of the facility to determine if Resident 1's belongings were accounted for before giving them to Resident 1's POA and the inability to look for any missing items. This deficient practice had the potential for other residents' property to be unaccounted for.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including schizoaffective disorder (combination of two mental illnesses which include schizophrenia [a mental health condition which causes hallucinations (when a person hears, sees, smells, tastes or feels things which appear to be real but only exist in the mind)], delusions [a belief which is clearly false and which indicates an abnormality in the affected person's content of thought), a mood disorder, and depression (constant feeling of sadness and loss of interest which stops a person from doing their normal activities).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 1/4/2024, the H&P indicated Resident 1 had a fluctuating 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 3/12/2024, the MDS indicated Resident 1's cognitive (thinking process) skills for daily decision-making were modified (had some difficulty in new situations only).</p> <p>During a review of Resident 1's Nursing Home to Hospital Transfer Form, dated 3/12/2024 and timed at 9:40 p.m., the Nursing Home to Hospital Transfer Form indicated Resident 1 was transferred to a GACH for behavioral issues (3/12/2024).</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 0584</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 GACH Discharge Aftercare Plan, the GACH Discharge After care Plan indicated Resident 1 was discharged from the GACH and transferred to a different Skilled Nursing Facility (SNF) on 3/22/2024.</p> <p>During a review of Resident 1 ' s Inventory List, dated 1/3/2023, the Inventory List indicated one cell phone(1/3/2023). The discharge section of Resident 1 ' s Inventory List and the section that indicated I received on discharge in satisfactory condition the above articles, was left blank without the signature of facility representative and the POA.</p> <p>During a telephone interview on 6/14/2024 at 12:48 p.m., Resident 1 ' s POA, stated when she picked up Resident 1 ' s belongings (4/16/2024) the Social Service Director (SSD) did not review Resident 1 ' s inventory list with her (POA) to verify that all of Resident 1 ' s belongings were accounted for, and the belongings matched what was on the Inventory List. The POA stated upon returning home and going through Resident 1 ' s belongings, that were given to her by the SSD, she noticed Resident 1 ' s cell phone was missing. The POA stated she did not think of going through Resident 1 ' s belongings while she was at the facility because she was not aware of the facility ' s process. The POA stated on 5/28/2024 she informed the SSD that Resident 1 ' s cell phone was missing.</p> <p>A review of a text message dated 5/28/2024 and timed at 9:49 a.m., between the POA and the SSD indicated the following:</p> <p>POA: Who would you suggest I speak with about Resident 1 ' s missing cell phone (it was only 3-4 months old Samsung)? I really think it ' s important to make the Admin aware of this!!</p> <p>SSD: Oh wow I will let him know. Of course, I will look around.</p> <p>During an interview on 6/14/2024 at 2:12 p.m., the SSD stated on 5/28/2024 Resident 1 ' s POA reported that Resident 1 ' s cell phone was missing. The SSD stated she did not review Resident 1 ' s Inventory List and she did not confirm with Resident 1 ' s POA that all of Resident 1 ' s belongings were accounted for when Resident 1 ' s POA was given Resident 1 ' s belongings at the time Resident 1 ' s POA was present at the facility. The SSD stated she did not sign, nor did she have the POA sign Resident 1 ' s Inventory List before Resident 1 ' s POA took Resident 1 ' s belongings with her.</p> <p>A review of the facility ' s P&P titled, Theft & Loss, revised 4/2013, the P&P indicated the facility shall inventory and surrender resident personal effects and valuables upon discharge to the resident or authorized representative in exchange for a signed receipt.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 report Resident 1 ' s debit card was missing to the California Department of Health (CDPH), State Long Term Care Ombudsman (assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) and the local police department (PD) within the regulated time frame of 24 hours for one of three sampled residents (Resident 1).</p> <p>This deficient practice resulted in the delayed investigation of Resident 1 ' s missing debit card, by CPDH, which resulted in 325 unauthorized debit card transactions totaling approximately \$11,254.00 from 12/21/2023 through 5/23/2024.</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 on [DATE] with diagnosis including schizoaffective disorder (combination of two mental illnesses which include schizophrenia [a mental health condition which causes hallucinations (when a person hears, sees, smells, tastes or feels things which appear to be real but only exist in the mind)], delusions [a belief which is clearly false and which indicates an abnormality in the affected person ' s content of thought], a mood disorder, and depression (constant feeling of sadness and loss of interest which stops a person from doing their normal activities).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 1/4/2024, the H&P indicated Resident 1 had a fluctuating 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 3/12/2024, the MDS indicated Resident 1 ' s cognitive (thinking process) skills for daily decision-making were modified (had some difficulty in new situations only).</p> <p>During a review of Resident 1 ' s Nursing Home to Hospital Transfer Form dated 12/21/2023 and timed at 12:33 p.m., the Nursing Home to Hospital Transfer Form, indicated Resident 1 was transferred to a General Acute Care Hospital (GACH) for behavioral issues (12/21/2023).</p> <p>During a review of Resident 1 ' s Clinical Census Report, the Clinical Census Report indicated Resident 1 was readmitted to the facility on [DATE].</p> <p>During a review of Resident 1 ' s Bank Statements dated 12/3/2023 to 1/3/2024, the Bank Statements indicated 59 debit transactions were made, totaling approximately \$1,914.00, during Resident 1 ' s stay at the GACH from 12/21/2023 to 1/3/2024.</p> <p>During a review of Resident 1 ' s Nursing Home to Hospital Transfer Form, dated 3/12/2024 and timed at 9:40 p.m., the Nursing Home to Hospital Transfer Form indicated Resident 1 was transferred to a GACH for behavioral issues (3/12/2024).</p> <p>(continued on next page)</p>

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<p>F 0609</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 GACH Discharge Aftercare Plan, the GACH Discharge After care Plan indicated Resident 1 was discharged from the GACH and transferred to a different Skilled Nursing Facility (SNF) on 3/22/2024.</p> <p>During a review of Resident 1 ' s Bank Statements dated 3/13/2024 to 5/23/2024, the Bank Statements indicated 266 debit transactions were made totaling approximately \$9,340.00, during Resident 1 ' s stay at the GACH from 3/12/2024 to 3/22/2024.</p> <p>During a review of a text message dated 5/14/2024 and timed at 9:33 a.m., between the POA and the SSD, the text message indicated the following:</p> <p>POA: Resident 1 ' s debit card was missing for several months and there are several thousands of dollars in gas, food, etc. near the facility and the purchases are still occurring.</p> <p>SSD: O wow, I would immediately cancel the card and honestly I don ' t know who would have the card.</p> <p>During a review of a text message dated 5/28/2024 and timed at 9:49 a.m., (14 days after the POA initially reported the missing debit card to the SSD) between the POA and the SSD, the text message indicated the following:</p> <p>POA: Who would you suggest I speak with about Resident 1 ' s missing debit card? I really think it ' s important to make the Admin aware of this!!</p> <p>SSD: Oh wow I will let him know. Is the card still being used? Did you file a police report, I ' m sorry this is happening, but I have no idea who would have it.</p> <p>POA: As of last week, it is still being used all around the care center - and online orders for women ' s clothing and marijuana shops nearby .thousands and thousands of dollars.</p> <p>SSD: Wow I will report it.</p> <p>During a review of a text message dated 5/30/2024 and timed at 12:50 p.m., (16 days after the POA initially reported the missing debit card to the SSD) between the POA and the SSD, the text message indicated the following:</p> <p>POA: Good afternoon, can you share the response/info from the administration regarding what they said about the missing debit card please?</p> <p>SSD: Administration is off this week but when he comes back, I ' ll share it, I don ' t have anything right now.</p> <p>During a review of a text message dated 6/3/2024 and timed at 2:34 p.m., (20 days after the POA initially reported the missing debit card to the SSD) between the POA and the SSD, the text indicated the following:</p> <p>POA: I really think it ' s important that I speak with the director about Resident 1 ' s missing debit card. How do I reach the director please?</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a text message dated 6/3/2024 and timed at 4:42 p.m., between the SSD and the POA, the text message indicated the following:</p> <p>SSD: I understand let me reach out to him.</p> <p>During a review of a text message dated 6/5/2024 and timed at 1:07 p.m., (22 days after the POA initially reported the missing debit card to the SSD) between the POA and the SSD, the text message indicated the following:</p> <p>POA: I have all the bank statements showing all the fraud charges made to Resident 1 ' s account. I think the next step is to make an appointment with the director to discuss and show this information in person.</p> <p>During a review of a text message dated 6/7/2024 and timed at 11:17 a.m., (24 days after the POA initially reported the missing debit card to the SSD) between the POA and the SSD, the text message indicated the following:</p> <p>POA: When you can send a quick update, please.</p> <p>SSD: The admin will let me know when he ' s available.</p> <p>During a telephone interview on 6/14/2024 at 12:48 p.m., Resident 1 ' s Power of Attorney ([POA] legal authorization for a designated person to make decisions about another person ' s property, finances, or medical care) stated she informed the facility ' s Social Services Director (SSD) on 5/14/2024 that Resident 1 ' s debit card was lost and/or stolen for several months. The POA stated she informed the SSD that Resident 1 ' s bank statements reflected the debit card had been used several times at places that were in close proximity to the facility, and she (the POA) requested a meeting with administration but never heard back from them. The POA stated there was no way Resident 1 could have used his debit card because he currently resided at a SNF which was not located in the same city where the debit card had been used.</p> <p>During an interview on 6/14/2024 at 2:12 p.m., the SSD stated Resident 1 ' s POA made her aware that Resident 1 ' s debit card was missing on 5/14/2024. The SSD stated she did not report that Resident 1 ' s debit card was missing to CDPH, the Ombudsman, or the local PD because the Resident 1 was no longer at the facility at the time she was informed of the missing debit card, and she did not notify the Administrator (ADM) that Resident 1 ' s debit card was missing until 5/28/2024 (14 days after she was made aware by the POA that Resident 1 ' s debit card was missing). The SSD stated in hindsight, she should have reported the missing debit card to the local PD, CDPH and the Ombudsman so an investigation could be conducted because there was a potential for other residents in the facility to be affected if someone in the facility was taking Residents ' debit cards and using Resident ' s money without authorization.</p> <p>During an interview on 6/18/2024 at 4:33 p.m., the ADM stated he was not made aware of Resident 1 ' s missing debit card until 6/14/2024 (1 month after Resident 1 ' s POA reported to the SSD that Resident 1 ' s debit card was missing). The ADM stated he was not aware he needed to report Resident 1 ' s missing debit card to CDPH, the Ombudsman and the local PD because Resident 1 no longer resided at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s policy and procedure (P/P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 10/2022, indicated it is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 24 hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury.</p>		