STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055894	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway by the Sea	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)
F 0656 Level of Harm - Actual harm Residents Affected - Few	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** 45425 Based on interview and record review, the facility failed to ensure the resident, who was assessed at risk for falls with poor safety awareness, did not fall and sustained injury for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1's untitled care plan, dated 7/5/2024, identifying the resident as fall risk, had specific interventions used and carried out to prevent the resident from falls and injuries. 2. Ensure untitled care plan, dated 7/5/2024, identifying Resident 1 as fall risk, was reviewed and revised after the resident's fall on 8/20/2024, to have specific interventions to safeguard the residents from future falls and injuries. 3. Ensure staff has taken precautions (unspecified) to prevent Resident 1 falls as indicated in untitled care plan dated 7/8/2024, for the anticoagulant (blood thinner) therapy. 4. Ensure staff followed the facility's policy and procedure (P/P) titled Fall Management System dated 12/2023, which 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. These deficient practices resulted in Resident 1's unwitnessed fall on 10/24/2024 and sustaining injuries leading to resident's transfer to the General Acute Care Hospital (GACH) d admission to the Intensive Care Unit ([ICU] critical care unit in the hospital that takes care of patients who are critically ill) where Resident 1 was diagnosed with an 8.0 millimeters ([mm] a unit of measure of length) subdural (one of the tissue layers of the brain) hematoma (a collection of blood after a head injury) and an acute hyperextension (forceful extension of a joint beyond its normal limits) fracture [a break] in the spine that involves a triangular fragment of bone) of the C6 (bone located at the base of the neck) vertebral body (bone in the neck). While at the GACH Resident 1 was intubated (a tube inserted into a person's mouth or nose, then into their windpipe to help deliver oxygen to the body) following with tracheostomy (a surgical opening through the neck into the windpipe to allow air to fill the lungs), and on 11/12/2024 had a [NAME] (a small, rotating cutting tool used by surgeons and dentists to remove or reshape bone) hole evacuation (a surgical procedure that involves drilling small holes in the skull to drain blood or excess fluid) for the treatment of the subdural hematoma. On 12/9/2024 Resident 1 undergone cervical (the neck) bone to thoracic (chest) bone fusion (the process of combining two or more things into one) and decompression (to release pressure) . surgery. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation ([A-Fib], irregular heartbeat), repeated falls, dementia (a progressive state of decline in mental abilities), and traumatic subdural hemorrhage (secondary to a fall pre-admission). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool) dated 10/25/2024, the MDS indicated Resident 1 was moderately independent (some difficulty in new situations) in daily decision making and required partial/moderate assistance (helper does less than half the effort) in completing activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician Order dated 7/5/2024, the Physician Order indicated to administer Apixaban (medication to thin the blood and prevent clots) 5.0 milligrams ([mg] a unit of measurement of mass) one tablet by mouth two times a day for A-Fib. During a review of Resident 1's Fall Risk Evaluation dated 7/5/2024, the Fall Risk Evaluation indicated Resident 1 scored a ten indicating Resident 1 was a medium risk for falls. During a review of Resident 1's untitled care plan dated 7/5/2024, the care plan indicated Resident 1 was a high risk for falls related to recurrent falls and getting up unassisted despite encouragement not to do so. The care plan indicated the interventions included reviewing information on past falls, determining causes of the falls, and removing any potential causes if possible. During a review of Resident 1's untitled care plan dated 7/8/2024, the care plan indicated Resident 1 was on anticoagulant therapy related to A-Fib and was at risk for bruising (skin discoloration from damaged, leaking blood vessels underneath the skin), bleeding, and related complications. The care plan's interventions included resident/family/caregiver teaching to include avoiding activities that could result in injury and to take precautions to avoid falls. During a review of Resident 1's Change in Condition (COC) dated 8/20/2024 and timed at 10:17 a.m., the COC indicated Resident 1 had fallen out of his wheelchair when he was trying to get to his bed, the resident stood up and slid from the wheelchair. During a review of Resident 1's Fall Risk evaluation dated 8/20/2024, the Fall Risk Evaluation indicated Resident 1 was a high risk for falls. During a review of Resident 1's Fall Committee Interdisciplinary Team ([IDT] a group of health care professionals from different disciplines who work together to provide care) note dated 8/21/2024, the Fall Committee IDT note indicated the root cause of Resident 1's fall on 8/20/2024 was due to Resident 1was initiating self-transfer and not asking for assistance. During a review of Resident 1's Physical Therapy ([PT] treatment to improve how the body performs physical movements) Discharge Summary dated 8/29/2024, the PT Discharge Summary indicated Resident 1 required supervision or touching assistance (helper makes light contact to guide or stabilize the person) during transfers and ambulation (walking). The PT Discharge Summary indicated Resident 1 required ongoing cueing (to give instructions) due to poor safety awareness. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Fall Committee IDT note dated 9/18/2024 (28 days from the fall on 8/20/2024), the Fall Committee IDT note indicated a recommendation to remove Resident 1 from the Fall Committee on this date (9/18/2024). The note indicated there were no incidence of Resident 1's fall or injury, and interventions (unspecified) were effective at this time. During a review of Resident 1's COC dated 10/24/2024 and timed at 11:30 p.m., the COC indicated Resident 1 had experienced a fall which resulted in swelling on the left side of his forehead and upper left eyelid. During a review of Resident 1's Physician Order dated 10/24/2024, the Physician Order indicated to transfer Resident 1 to the GACH for further evaluation and treatment. During a review of the Paramedic (emergency medical response team) Report Sheet dated 10/24/2024, the Paramedic Report Sheet indicated Resident 1 sustained an unwitnessed ground level fall (a fall that happens when someone is standing, and their feet touch the ground before they fall) and Resident 1 had a one inch laceration (a wound that is produced by the tearing of soft body tissue) to the left side of his forehead. During a review of Resident 1's Fall Committee IDT note dated 10/25/2024 and timed at 9:34 a.m., the Fall Committee IDT noted indicated after hearing an unfamiliar sound coming from Resident 1's room, Resident 1 was found by the Licensed Vocational Nurse 2 (LVN 2) lying on the floor by the bedside table near the bed. The Fall Committee IDT note indicated Resident 1 reported to LVN 2 that he heard his daughter calling him and he was going to meet her when he stood up from the bed. The Fall Committee IDT note indicated on 10/24/2024 Resident 1 was transferred to the GACH for further evaluation due to Resident 1 being on anticoagulant medication. The Fall Committee IDT note indicated the IDT team concluded Resident 1 tried to get out of bed unassisted, lost his balance and fell on the floor. During a review of Resident 1's Emergency Department (ED) Physician Notes dated 10/25/2024 and timed at 10:25 a.m., the ED Physician Note indicated Resident 1 was found to have an acute (sudden onset) subdural hematoma, and was admitted to ICU, where he was administered Kcentra medication (reverses the effects of a blood thinning medication in adult with acute major bleeding) for urgent reverse of Apixaban effect. During a review of Resident 1's Computerized Tomography Scan ([CT]- a type of imaging that uses radiography (a procedure that uses beams of light to create an image of a body part) techniques to created detailed images of the body) of the Spine (bones and other tissues that reach from the base of the skull to the tailbone) dated 10/25/2024, the CT Scan of the Spine indicated Resident 1 had acute hyperextension fracture of the C6 vertebral body. During a review of Resident 1's CT scan of the head dated 10/25/2024, the CT scan of the head indicated an 8.0 mm acute subdural hematoma. During a review of Resident 1's Operative Report dated 12/9/2024, the Operative Report indicated Resident 1 had Cervical bone to Thoracic bone fusion and decompression During a review of Resident 1's GACH's Discharge Summary dated 12/23/2024, the Discharge Summary indicated Resident 1 had a [NAME] hole evacuation on 11/12/2024 for treatment of the subdural hematoma. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/11/2025 at 2:00 a.m., with Certified Nursing Assistant (CNA) 1, the CNA 1 stated for residents who were high risk for falls and were attempting to get out of bed unassisted, she would check on them every two hours, sit close to their room, and keep an eye on them. During an interview on 2/11/2025 at 2:03 a.m., with LVN 1, the LVN 1 stated a resident (in general), who were high risk for falls, required frequent monitoring every two hours. LVN 1 stated for residents, who were getting out of bed unassisted, she would assign a 1:1 sitter (a person provides constant supervision) because the resident needs constant redirection and monitoring. During an interview on 2/11/2025 at 12:52 p.m., with the Physical Therapist (PT 1), the PT 1 stated Resident 1 required contact guard (lightly touching the resident to help with balance or stability) during ambulation due to Resident 1's poor safety awareness. During an interview on 2/11/2025 at 1:42 p.m., with Registered Nurse 1 (RN 1), the RN 1 stated Resident 1 was a high risk for falls. RN 1 stated residents, who had dementia and were high fall risk, required reminders to use the call light (to call for assistance), rounding (checking on the resident) and monitoring at least every two hours to ensure their safe. During an interview on 2/11/2025 at 2:07 p.m., with the Director of Nursing (DON), the DON stated when a resident (in general) is admitted to the facility, upon admission a fall risk assessment is completed and if needed, a care plan related to falls is created. The DON stated when a resident (general) sustains a fall, a rehabilitation screen is completed, the root cause of the fall is investigated and discussed with the IDT team, and the resident's care plan will be updated. The DON stated for Resident 1, frequent monitoring and visual checks every two hours should have been added to the care plan and implemented. The DON stated that if Resident 1 was frequently monitored, it could have decreased his chances of falling. The DON stated Resident 1 would have benefited from having a 1:1 sitter assigned to him. According to the National Institute of Health's ([NIH] the primary agency of the United States government responsible for conducting and supporting medical research) article titled Anticoagulant use in older persons at risk for falls: therapeutic dilemmas, dated 7/1/2023 the article indicated anticoagulants may increase the risk of intracranial hemorrhage, internal bleeding, prolonged bleeding due to falls. The article indicated assessing and modifying risk factors for falls and bleeding can make anticoagulant therapy safer. https://pmc.ncbi.nlm.nih.gov During a review of the facility's policy and procedure (P/P) titled Fall Management System dated 12/2023, the P/P indicated residents with 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 risk factors and will consider the particular elements of the evaluation that put the resident at risk. The P/P indicated after a resident sustains a fall, the resident's care plan will be updated.

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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** 46415 Based on interview and record review, the facility failed to ensure to have a documented monitoring of intervention effectivness for one of two sampled residents (Resident 3) who was a high risk for falls had a care plan for a 1:1 sitter (a health care professional who provides constant care and supervision for a patient). This deficient practiceof not documenting, monitoring and assessing intervension for Resident 3 had the potential for ineffective interventions to prevent falls to continue. During a review of Resident 3 ' s Admission record, the Admission Record indicated Resident 3 was admitted on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is disrupted), dementia (a progressive state of decline in mental abilities), and atrial fibrillation (AFib: irregular heart rhythm). During a review of Resident 3 ' s History and Physical (H&P) dated 11/27/2024, the H&P indicated Resident 3 has fluctuating capacity to make decisions. During a review of Resident 3 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 1/16/2025, the MDS indicated Resident 3 ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses)skills were mildly impaired. The MDS indicated Resident 3 required supervision to perform Activities of Daily Living (ADLs: activities such as bathing, dressing and toileting). During an interview on 3/14/2025 at 11:46 a.m. with the Director of Nursing (DON), the DON stated Resident 3 required constant redirection and indicated Resident 3 fell in the bathroom when the Certified Nursing Assistant (CNA) that was a 1:1 sitter gave him privacy (while using the bathroom). During a concurrent observation and interview on 3/14/2025 at 11:57 a.m., with the DON, Resident 3 was observed with the bed at the lowest position, call light reachable, no fall mats, and a 1:1 sitter. The DON stated another licensed staff, or a resident escort can also be a sitter, so they ensure everyone gets in-serviced regarding being a sitter. The DON stated the Director of Staff Development (DSD) makes rounds, they do not have a physicians order to have a sitter, and Resident 3 has a sitter since he had multiple falls. The DON stated they do not have a care plan for the sitter, but they will have a sitter care plan. During a concurrent interview and record review on 3/14/2025 at 12:28 p.m,. with the DON, the DON stated in Resident 3 ' s fall care plan, there was no documentation and monitoring of interventions regarding Resident 3 having a sitter. The DON stated she does not see a care plans for a sitter and no physican's orders. The DON stated when a sitter is required, the charge nurse will document if there are episodes such as Resident 3 trying to get up unassisted, and if Resident 3 does not exhibit any behaviors and is stable, they can reconvene and assess whether Resident 3 still requirds a sitter. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2025 at 12:5 8p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 sated she has been sitting for Resident 3 for a couple of days to prevent him from falling and getting hurt. CNA 1 stated she reports to the charge nurse any behavior Resident 3 exhibits such as trying to get up unassisted. CNA 1 stated Resident 3 requires assistance when going to the bathroom, but when a Certified Nursing Assistant (CNA) tries to assist, he resists. CNA 1 stated Resident 3 uses the call light every now and then and has tried to get up multiples times while she has been sitting for him. CNA 1 stated Resident 3 uses the bathroom often and tries to get up a couple of times a day on his own to use the bathroom, so she redirects and have to wait for a CNA to provide care. CNA 1 stated Resident 3 tries to get up a little more than four (4) time a day to go to the bathroom on his own, and can ambulate but is unsteady. CNA 1 stated Resident 3 benefits from having a sitter to prevent him from falling and indicated without a sitter he would have more falls. During an interview on 3/14/2025 at 1:08p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated residents who are a fall risk and have behavioral concerns require sitters. LVN 1 stated Resident 3 is anxious, tries to get up without assistance, and is noncompliant with the use of call lights. LVN 1 stated since there is a sitter, she does not really document Resident 1's behaviors or attemtps to get up unassisted. LVN 1 stated it is beneficial to monitor for how many behaviors a resident exhibist as they can change the interventions and determine whether the behavior is improving as the goal is to eventually remove the sitter. LVN 1 reiterated if Resident 3 did not have a sitter, he would try and get up on his own despite redirecting. During an interview on 3/14/3025 at 1:39p.m. with Director of Staff Development (DSD), the DSD stated Resident 3 had multiple falls and having a sitter would be a part of the intervention under fall risk. The DSD stated the CNA should notify the charge nurse daily for any changes in behavior and the charge nurse should document them. The DSD stated she is not sure what they are monitoring for and how it would be documented.The DSD stated there is nothing in place to show how many episodes the resident has tried to get up and monitor to see whether or not the requires a sitter or more interventions. The DSD stated a fall care planould indicate the focus and intervention to prevent the resident from falling again. The DSD stated if there was no care plans, they would not know the plan and what they are doing to prevent the falls from occurring. During an interview on 3/14/2025 a 2:04 p.m. with DON, the DON stated the IDT recommendes for the resident to have a 1:1 sitter. The DON stated they do not document in the progress note unless there is a Change of Condition (COC), then the IDT will reconvene and discuss to see if a sitter is appropriate or more interventions are needed.The DON stated Resident 3 still needs a sitter as he is having episodes of trying to get up from bed but there is no documentation that indicated Resident 3 is being monitored for safety. The DON stated having a sitter is effective in preventing falls as all of the other interventions have been exhausted and Resident 3 has not had any falls. The DON stated Resident 3 will continue to have a sitter due to the safety for the resident. DON stated when the resident is reassessed, they would interview the staff and receive a verbal confirmation from the sitter if a resident is having episodes of trying to get out of bed. During a review of the facility ' s policy and procedure (P&P) titled, Sitter Program, dated 3/2025, the P&P indicated the care plan will reflect when resident is assigned to the Sitter Program. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled, Comprehensive Resident Centered Care Plan, 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 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. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45425 Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 2) who was a high risk for falls was supervised and assisted. The facility failed to ensure the 1:1 sitter (a health care professional who provides constant care and supervision for a patient) assigned to Resident 2 was frequently monitoring and providing visual checks while Resident 2 was in the restroom. This deficient practice resulted in Resident 2 sustaining three unwitnessed falls in the month of 1/2025. Findings: During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted on [DATE] with diagnoses of cerebral infarction (when the blood flow to the brain is disrupted due to issues with the arteries that supply it), dementia (dementia (a progressive state of decline in mental abilities) and atrial fibrillation (A. Fib, an irregular heartbeat). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognition was moderately impaired and Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes the activity) to complete Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily. During a review of Resident 2 ' s Fall Risk Evaluation dated 11/23/2024, the Fall Risk Evaluation indicated Resident 2 was a high risk for falls. During a review of Resident 2 ' s physician order dated 11/23/2024, the physician order indicated to give Resident 2 Apixaban 5 milligrams (mg, unit of measurement) one tablet by mouth two times a day for A. Fib. During a review of Resident 2 ' s untitled care plan revised on 12/11/2024 related to Resident 2 ' s risk for bruising, bleeding, and other related complications due to Resident 2 ' s use of anticoagulant, the care plan indicated interventions including resident/family/caregiver teaching to include avoiding activities that could result in injury and to take precautions to avoid falls. During a review of Resident 2 ' s untitled care plan revised on 12/23/2024 related to Resident 2 ' s high risk for falls related to getting out of bed unassisted, requiring assistance for ADLs, and non-compliance with waiting for assistance, the care plan indicated providing frequent visual checks and transferring resident with one to two staff assistance. During a review of Resident 2 ' s Change of Condition (COC) note dated 1/7/2025, the COC indicated Resident 2 attempted to go to the bathroom without assistance, Resident 2 lost his balance which resulted in an unwitnessed fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s COC note dated 1/8/2025, the COC note indicated Resident 2 was on monitoring due to an unwitnessed fall and had a 1:1 sitter at bedside. During a review of Resident 2 ' s COC note dated 1/12/2025, the COC note indicated Resident 2 experienced a fall. During a review of Resident 2 ' s Fall Committee Interdisciplinary Team (IDT- A group of health care professionals from different disciplines who work together to provide care) dated 1/16/2025, the Fall Committee IDT note indicated on 1/12/2025, Resident 2 was heard screaming, facility staff went to Resident 2 ' s room immediately and found Resident 2 on the bathroom floor next to the toilet. The Fall Committee IDT note indicated Resident 2 has poor safety awareness, did not call for assistance, lost his balance and fell on the floor. The Fall Committee IDT note indicated the Certified Nursing Assistant (CNA 1) assigned to the resident provided Resident 2 with privacy while using the bathroom. During a review of Resident 2 ' s COC dated 1/25/2025, the COC note indicated Resident 2 got up unassisted and walked to the restroom and the Certified Nursing Assistant 2 (CNA 2) rushed to Resident 2 as he slid to the floor. During a review of Resident 2 ' s Fall Committee IDT note dated 1/31/2025, the Fall Committee IDT note indicated on 1/25/2025, Resident 2 ' s bathroom call light was on, and the charge nurse found Resident 2 sitting on the bathroom floor in front of the sink and his walker. The Fall Committee IDT noted indicated the assigned CNA 2, was waiting outside of the bathroom door, she heard Resident 2 calling for help, CNA 2 opened the door and found Resident 2 sitting on the floor. The Fall Committee IDT note indicated Resident 2 lost his balance due to an unsteady gait and Resident 2 has poor safety awareness. During an interview on 2/10/2025 at 1:52 p.m., with CNA 3, CNA 3 stated Resident 2 requires 1:1 supervision because Resident 2 is a fall risk, and he will try to get up out of bed on his own. CNA 3 stated Resident 2 has fallen twice in one week this month on the night shift. CNA 3 stated when she assists Resident 2 to the bathroom, she will stay in the bathroom with him to help him stand up and ensure he does not fall. During an interview on 2/10/2025 at 2:24 p.m. with Registered Nurse 1 (RN 1), RN 1 stated Resident 2 requires 1:1 supervision because he has fallen and tries to get up without assistance. RN 1 stated Resident 2 has had 1: 1 supervision for at least the last three months. During an interview on 2/11/2025 at 12:04 p.m., with CNA 2, CNA 2 stated Resident 2 required supervision when he is walking, he could go to the bathroom on his own, and he was independent. CNA 2 stated Resident 2 would request for privacy while using the bathroom. CNA 2 stated she was unsure why Resident 2 required 1:1 supervision. CNA 2 stated on 1/25/2025, she helped Resident 2 to the restroom, she waited by the door, which was slightly opened, then she heard Resident 2 yelling, and she found him sitting on the floor of the bathroom. CNA 2 stated the fall could have been prevented if she was doing frequent visual checks on Resident 2 while he was using the restroom. CNA 2 stated Resident 2 does require one person assistance for transfers on/off the toilet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055894	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway by the Sea	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/2025 at 12:52 p.m. with Physical Therapist (PT 1), PT 1 stated Resident 2 has poor exercise tolerance, and some days Resident 2 will complain his legs or knees are hurting and might need a break and sit down. PT 1 stated Resident 2 requires stand by assist (close enough to touch if needed) with ambulation and transfers and he will provide Resident 2 privacy when he is uses the bathroom, but PT 1 is outside the door and always has Resident 2 in his line of sight just in case Resident 2 attempts to stand up without assistance. During an interview on 2/11/2025 at 2:07 p.m. with the Director of Nursing (DON), the DON stated when a resident is admitted to the facility, upon admission a fall risk assessment is completed and if needed, a care plan related to falls is created. The DON stated when a resident sustains a fall, a rehabilitation screen is completed, the root cause of the fall is investigated and discussed with the IDT team, and the resident ' s care plan will be updated. The DON stated for Resident 1, frequent monitoring and visual checks done by facility staff. The DON stated that if Resident 1 was frequently monitored, it could have decreased his chances of him falling. The DON stated Resident 1 would have benefited from having a 1:1 sitter assigned to him. The DON stated Resident 2 should have been closely monitored to ensure safety and decrease the chances of him falling. The DON stated the facility staff who were assigned as a 1:1 sitter should have been closely monitoring him with frequent visual checks while Resident 2 is in the bathroom. During a review of the facility ' s policy and procedure (P/P) titled Fall Management System dated 12/2023, the P/P indicated it is the policy of the facility to provide an environment that remains free of accidents hazards as possible. The P/P indicated it is the policy of the facility to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.