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	06/18/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was exhibiting signs and symptoms of depression (serious mental condition that negatively affects how one feels, thinks, and acts), and had an order for psychiatric evaluation (medical doctor specializing in the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) on 2/27/2025, 3/11/2025, and 6/3/2025, was seen by the psychiatrist as ordered and signs and symptoms of depression were monitored as indicated in Resident 1's Care Plan. These failures resulted in Resident 1 experiencing worsening symptoms of depression which included loss of interest in activities and excessive sleepiness. These failures had the potential for Resident 1 to have intense feelings of sadness, hopelessness which could lead to suicidal thoughts, attempts, and even death. Findings: 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 diagnoses including history of mental and behavioral disorders (disorders affects how one acts, thinks, and feels), history of physical injury and trauma, and colostomy (colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body). During a review of Resident 1's History and Physical (H&P) dated 7/22/2024, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/14/2024, the MDS indicated Resident 1's cognition (ability to register and recall information) was intact and had the ability to understand and be understood by others. The MDS indicated Resident 1 was feeling down, depressed, or hopeless never or one day during the assessment period. The MDS indicated Resident 1 had little interest or pleasure in doing things two to six days (several days) during the assessment period. During a review of Resident 1's Care Plan, revised 7/11/2024, the Care Plan indicated Resident 1 had a potential for psychosocial well-being problem related to pain. The Care Plan goals indicated Resident 1 will have no indications of psychosocial well-being problems, will verbalize feelings related to emotional state, and will demonstrate adjustment to nursing home placement. The Care Plan interventions included psychiatric consultation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 felt down, depressed, or hopeless for two to six days (several days) during the assessment period and had little interest or pleasure in doing things seven to 11 days (half or more of the days) during the assessment period. During a review of Resident 1's Change of Condition (COC) Note, dated 2/27/2025, the COC indicated Resident 1 verbalized to Licensed Vocational Nurse (LVN 1) he was feeling depressed due to all the things he has been through and things he has done in his life, which are now catching up to him. The COC indicated Resident 1's physician was notified, and an order was received for Resident 1 to have a psychiatric consult/evaluation. During a review of Resident 1's Order Summary Report (Physician's Orders), dated 2/27/2025, indicated an order was received for Resident 1 to have a psychiatric consult/evaluation for symptoms of depression, ordered on 2/27/2025. During a review of Resident 1's Care Plan, revised 2/28/2025, the Care Plan indicated Resident 1 was at risk for depression related to expressing feelings of sadness. The Care Plan goals indicated Resident 1 will exhibit indicators of depression, anxiety (common emotion characterized by feelings of worry, unease, and fear) or sad mood less than daily. The Care Plan interventions included arranging for psychiatric consult and follow up as indicated. During a review of Resident 1's Order Summary Report, dated 3/11/2025, indicated an order was received for Resident 1 to have a psychiatric consult for depression, ordered on 3/11/2025. During a review of Resident 1's Care Plan, revised on 3/11/2025, the Care Plan indicated Resident 1 is at risk for depression. Under this Care Plan the goals indicated Resident 1 will exhibit indicators of depression, anxiety or sad mood less than daily, and will remain free of signs and symptoms of distress, symptoms, of depression, anxiety or sad mood. The Care Plan's interventions included staff are to monitor, document, and report to the nurse or medical doctor signs and symptoms of depression including hopelessness, anxiety, sadness, insomnia (sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunity to sleep), verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. The Care Plan's interventions included arranging for psychiatric consult and follow up as indicated. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/9/2025, the MDS indicated Resident 1's cognition was intact and had the ability to understand and be understood by others. The MDS indicated during the assessment period Resident 1: 1. Had poor appetite or was overeating two to six days (several days). 2. Had little interest or pleasure in doing things, felt tired or having little energy seven to 11 days (half or more of the days). 3. Felt down, depressed, or hopeless, and had trouble falling or staying asleep or slept too much 12 to 14 days (nearly every day). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Resident 1's Order Summary Report dated 6/3/2025, indicated an order was placed for Resident 1 to have psychiatric consult, ordered on 6/3/2025. During an interview on 6/17/2025 at 3 p.m., with Resident 1, Resident 1 stated he had been feeling depressed for several months. Resident 1 stated he felt depressed because he there were several days when he felt like sleeping all day and did not want to get up to do anything. Resident 1 stated he looked forward to the nighttime so he could go back to sleep. Resident 1 stated he has told the social worker and everyone he talked to. Resident 1 stated he has requested a psychiatric consult but has not been seen by anyone. Resident 1 stated, he felt frustrated and tired, and stated I do not like feeling like this, I don't feel myself, I'm usually a positive and happy guy. Resident 1 started to cry during the interview. During an interview on 6/17/2025, at 3:49 p.m. the Social Services Director (SSD) stated she was aware that Resident 1 was depressed and thought Resident 1 was already seen by a psychiatrist this past week. The SSD stated she could not locate any notes from the psychiatrist verifying whether Resident 1 was seen. The SSD stated she did not know Resident 1 had outstanding psychiatric consultation orders dated 2/27/2025 and 3/11/2025 that were not done and was only aware of the consult ordered on 6/3/2025. During a concurrent interview and record review on 6/18/2025 at 11:30 a.m. with the Assistant Director of Nursing (ADON), Resident 1's clinical record dated 2/2025 to 6/2025 was reviewed. The clinical record indicated a psychiatric consult was ordered on 2/27/2025, 3/11/2025, and 6/3/2025, however there was no documentation indicating Resident 1 was seen by the psychiatrist until 6/17/2025 nor documentation indicating Resident 1 was on behavior monitoring. The ADON stated Resident 1 had a COC on 2/27/2025 due to feeling depressed, LVN 1 notified Resident 1's physician and received an order on 2/27/2025 for Resident 1 to have a psychiatric consult but was never seen by the psychiatrist. The ADON stated Resident 1 had a second psychiatric consult ordered on 3/11/2025 and then a third psychiatric consult ordered on 6/3/2025 but was not seen by the psychiatrist until 6/17/2025. The ADON stated she was not aware of the orders placed on 2/27/2025, 3/11/2025, and on 6/3/2025 nor knew why the orders weren't carried out. The ADON stated after Resident 1 had increased feelings of depression, he should have had behavior monitoring such as sleepiness, sadness, change in appetite, or interruptions in sleep patterns as indicated in the Care Plan. During a follow up interview on 6/18/2025 at 2:30 p.m. with the SSD, the SSD stated she began working at the facility in 3/2025 and was not made aware of Resident 1's outstanding psychiatric consultation needs upon hire. The SSD stated the psychiatric consult should have been facilitated by the pervious SSD to ensure Resident 1 was seen as soon as possible and should have updated the Interdisciplinary Team ([IDT] group of professionals from different fields who work together to achieve resident goals) to ensure all team members were aware of Resident 1's plan of care. The SSD stated she was made aware of Resident 1's needs to see a psychiatrist sometime last week, but she did not document in Resident 1 was pending a psychiatric visit. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/2025, at 3 p.m., with the Director of Nursing (DON), the DON confirmed she could not find any progress notes or summaries indicating Resident 1 was seen by a psychiatrist until 6/18/2025 or that Resident 1's depression was monitored. The DON stated the licensed nurses are responsible for ensuring all orders are carried out and should have followed up with the SSD to ensure Resident 1 was seen by the psychiatrist in a timely manner. The DON stated the facility overlooked Resident 1's psychiatric consult orders and should have followed up to ensure Resident 1's behavioral needs and well-being were being met, which included monitoring Resident 1's behaviors. The DON stated there was a lack of communication amongst the IDT which led to Resident 1 psychiatric consults being missed. The DON stated by failing to facilitate Resident 1 in receiving a psychiatric consult, the facility placed Resident 1 at risk to suffer a decline in mental health and a decreased quality of life. During a review of the facility's policies and Procedures (P&P), titled Behavioral Health Services, revised 4/2025, the P&P indicated it is the policy of the facility to provide residents with necessary behavioral health care services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The P&P further indicated, the physician, in collaboration with the IDT team will determine the appropriate psychiatric or psychological treatment or rehabilitation services needed. Treatment will be provided as ordered by the physician, the social services will make the appropriate professional services referral, if needed, following agreement from the resident and or resident representative.