

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  09/16/2025
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 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>Based on observation, interview, and record review the facility failed to obtain Office Visit Summaries from the outpatient physician visits on 7/1/2025 and 9/3/2025 to follow physician treatment recommendations for one of one sampled resident (Resident 1). This deficient practice resulted in Resident 1 not receiving treatment for Onychomycosis (toenail fungus) of the right and left great (big) toes for two months (7/14/2025 to 9/16/2025). Findings:</p> <p>During an observation on 9/15/2025 at 2:55 p.m., Resident 1's right and left great toes appeared thick and discolored (yellowish/ grey color).</p> <p>During a review of Resident 1's admission Record, The admission Record indicated Resident 1 was admitted to the facility 7/30/2021 with diagnoses of type 2 diabetes (the body does not regulate blood sugar levels) and a history of falling.</p> <p>During a review of Resident 1's Minimum Data Set (MDS), a resident assessment tool) dated 8/7/2025, the MDS indicated Resident 1 had moderate cognitive impairment (a decline in one or more cognitive abilities, such as memory, attention, reasoning, language, and problem-solving).</p> <p>During a review of Resident 1's Progress Note dated 4/16/2025, the Progress Note indicated family member (FM)1 had care concerns related to Resident 1's toenails. The Progress Note indicated Resident 1 was to receive authorization to be seen by an outside podiatrist and the in-house wound care specialist would further assess the condition of the toenails.</p> <p>During a review of Resident 1's Nursing Progress Note dated 4/17/2025, the Nursing Progress Note indicated the wound care specialist (WDS) 1 evaluated Resident 1's right and left great toenails and diagnosed her with onychomycosis.</p> <p>During a review of Resident 1's Office Visit Note dated 4/29/2025, Resident 1 was seen by the outpatient podiatrist (PD) 1. The Office Visit Note indicated Resident 1 was seen for a diabetic foot checkup and nail fungus. The Office Visit Note indicated Resident 1's toenails had been causing her pain, and she was receiving treatment for the fungal infection on her toenails which involved a clear, medicated nail polish Ciclopirox 8% (medication used to treat fungus) External Solution). PD 1 ordered to continue the Ciclopirox 8% External Solution twice daily and follow up in two months to reassess nail condition and treatment progress.</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 0684</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 Office Visit Note dated 7/1/2025, Resident 1 was seen for a follow up by PD1. The Office Visit Note indicated Resident 1's primary concern was the appearance and condition of her toenails, which has been causing emotional distress (beyond normal sadness: Emotional distress involves a more intense level of suffering than everyday negative feelings) and depression. The Office Visit Note indicated there had been some improvement in the toenails, but they still appeared problematic. The Office Visit Note indicated that the plan for the Onychomycosis of the toenails was to continue the daily application of the Ciclopirox 8% External Solution for six months to one year and it was discussed with Resident 1 the need for continued management for continued improvement.</p> <p>During a review of Resident 1's Nursing Progress Note dated 7/10/2205, the Nursing Progress Note indicated FM 1 informed staff (unknown), PD1 had prescribed a new medication for the fungus (new medication for tinea pedis (athletes' foot) to the bottom of both feet) at Resident 1's last outpatient podiatrist visit was on 7/1/2025.</p> <p>During a review of Resident 1's Nursing Progress Note dated 7/12/2025 (11 days after podiatrist office visit), facility staff (unknown) spoke to PD1's office staff (unknown) and requested the Office Visit Notes from 7/1/2025 and a copy of the new prescription via fax.</p> <p>During a review of Resident 1's Physician Order placed 7/12/2025 (11 days after podiatrist office visit), a new order was placed for Ciclopirox Olamine External Cream 0.77% apply to plantar (bottom) of both feet topically one time a day for tinea pedis.</p> <p>During a review of Resident 1's Office Visit Summary dated 9/3/2025, Resident 1 was seen for a follow up by PD1. Per the Office Visit Summary, Resident 1 reported the condition of her feet was the same with no improvement. PD1 noted Resident 1's toenails continued to show fungal infection. The Office Visit Note indicated Resident 1 was to continue daily application of Ciclopirox 8% Solution for 6 months to one year on the toenails.</p> <p>During a review of Resident 1's Physician and Telephone Orders dated 9/3/2025, PD 1 ordered Resident 1 to continue with Ciclopirox 8% nail lacquer on toenails.</p> <p>During an interview on 9/16/2025 at 11:33 a.m., treatment nurse (TX)1 stated Resident 1 was no longer receiving treatment Ciclopirox 8% to the toenails was unsure why. TX 1stated, Resident 1 did not have an order to apply the treatment.</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>During an interview and concurrent record review on 9/16/2025 at 12 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 1's Resident 1's Office Visit Summaries with PD1 dated 7/1/2025 and 9/3/2025. The ADON stated there was no current order for Ciclopirox 8% nail lacquer for Resident 1 toenails and Resident 1 had not received the treatment for her toenails since 7/14/2025. The ADON stated the facility's Social Services Director (SSD) had to call and request the outpatient Office Visit Notes from the podiatrist (4/29/2025 and 9/3/2025) because they were not in Resident 1's chart prior to today (9/16/2025). The ADON stated she was unaware of the process for following up on Office Visit Notes. The ADON stated it was important to have the Office Visit Notes available right aware for continuity of care. The ADON stated the Office Visit Notes were obtained late for the 7/1/2025 podiatrist visit, and the orders should have been placed the same day or next day and not 11 days later. The ADON stated that according to the orders of PD1, Resident 1 should still be receiving treatment for her toenails and was unsure why the orders were not carried out. The ADON stated the physicians order for Ciclopirox 8% to the left and right great toes from July to September 2025 was missed and not implemented. The ADON stated this error caused potential for a delay in healing for Resident 1's left and right great toenail fungus.</p> <p>During an interview on 9/16/2025 at 12:58 p.m., with the Director of Nursing (DON) the DON stated it was important to follow and carry out physician's orders because it was part of the care of the residents to promote healing. The DON stated there was a possibility of causing a delay of care or slowing the progression of healing for missing an order for medication. The DON stated it was important to obtain a copy of the Office Visit Notes within 72 hours to ensure all recommendations and orders were followed through and carried out.</p> <p>During a review of the facility's Registered Nurse Job Description dated 12/17/2021, the job description indicated the Registered nurse was responsible for initiating requests for consultations and referrals and responding to requests from the resident, physician, or nursing staff. Registered Nurses job responsibilities included consulting with the physicians regarding resident evaluation and planning and developing the nursing services to be performed for the resident.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review the facility failed to follow physician's orders for one out of three sampled residents (Resident 1) who was receiving care from a podiatrist (foot doctor). This deficient practice resulted in Resident 1 not receiving Ciclopirox n 8% (medication to treat nail fungus) for two months (7/14/2025 to 9/16/2025) and had the potential to delay healing of the left and right great toes. Findings:</p> <p>During an observation on 9/15/2025 at 2:55 p.m., Resident 1's right and left great toes appeared thick and discolored (yellowish/ grey color).</p> <p>During a review of Resident 1's admission Record (face sheet), The admission Record indicated Resident 1 was admitted to the facility 7/30/2021 with diagnoses of type 2 diabetes (the body does not regulate blood sugar levels) and history of falling.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/7/2025, the MDS indicated Resident 1 had moderate cognitive impairment (a decline in one or more cognitive abilities, such as memory, attention, reasoning, language, and problem-solving).</p> <p>During a review of Resident 1's Progress Note type: IDT dated 4/16/2025, the Progress Note indicated family member (FM)1 had care concerns related to Resident 1's toenails. Per the Progress Note Resident 1 was to receive authorization to be seen by an outside podiatrist and the in-house wound care specialist would further assess the condition of the toenails.</p> <p>During a review of Resident 1's Nursing Progress Note dated 4/17/2025, the Nursing Progress Note indicated the wound care specialist (WDS) 1 evaluated Resident 1's right and left great toenails and diagnosed her with onychomycosis.</p> <p>During a review of Resident 1's Office Visit Notes dated 4/29/2025, Resident 1 was seen by the outpatient podiatrist (PD) 1. The Office Visit Notes indicated Resident 1 was seen for nail fungus. The Office Visit Notes indicated Resident 1's toenails had been causing her pain, and she was receiving treatment for the fungal infection on her toenails Ciclopirox 8% (antifungal medication). PD 1 ordered to continue the Ciclopirox 8% twice daily and follow up in two months to reassess nail condition and treatment progress.</p> <p>During a review of Resident 1's Office Visit Notes dated 7/1/2025, Resident 1 was seen for a follow up by PD1. The Office Visit Note indicated Resident 1's primary concern was the appearance and condition of her toenails, which has been causing emotional distress (intense level of suffering than everyday negative feelings) and depression. The Office Visit Note indicated there had been some improvement in the toenails, but they still appeared problematic. The Office Visit Note indicated that the plan for the Onychomycosis (fungal infection) of the toenails was to continue the daily application of the Ciclopirox 8% for six months to one year and it was discussed with Resident 1 the need for continued management for continued improvement.</p> <p>During a review of Resident 1's Physician and Telephone Orders dated 7/1/2025, PD 1 ordered Resident 1 to continue with Ciclopirox 8% on the toenails.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Office Visit Summary dated 9/3/2025, Resident 1 was seen for a follow up by PD1. The Office Visit Summary, Resident 1 reported the condition of her feet was the same with no improvement. PD1 noted Resident 1's toenails continued to show fungal infection. The Office Visit Note indicated Resident 1 was to continue daily application of Ciclopirox 8% for 6 months to one year on the toenails.</p> <p>During a review of Resident 1's Physician and Telephone Orders dated 9/3/2025, PD 1 ordered Resident 1 to continue with Ciclopirox 8% on the toenails.</p> <p>During an interview on 9/16/2025 at 11:33 a.m., with treatment nurse (TX)1, TX 1 stated Resident 1 was no longer receiving treatment Ciclopirox 8% to the toenails and has not received it for some time now. TX1 stated she was unsure why Resident 1 was not receiving the treatment on the toenails.</p> <p>During an interview and concurrent record review on 9/16/2025 at 12 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 1's Resident 1's Office Visit Summaries with PD1 dated 7/1/2025 and 9/3/2025. The ADON stated there was no current order for Ciclopirox 8% nail lacquer for Resident 1 toenails and Resident 1 had not received the treatment for her toenails since 7/14/2025. The ADON stated the facility's Social Services Director (SSD) had to call and request the outpatient Office Visit Notes from the podiatrist (4/29/2025 and 9/3/2025) because they were not in Resident 1's chart prior to today (9/16/2025). The ADON stated she was unaware of the process for following up on Office Visit Notes. The ADON stated it was important to have the Office Visit Notes available right away for continuity of care. The ADON stated the Office Visit Notes were obtained late for the 7/1/2025 podiatrist visit, and the orders should have been placed the same day or next day and not 11 days later. The ADON stated that according to the orders of PD1, Resident 1 should still be receiving treatment for her toenails and was unsure why the orders were not carried out. The ADON stated the physicians order for Ciclopirox 8% to the left and right great toes from July to September 2025 was missed and not implemented. The ADON stated this error caused potential for a delay in healing for Resident 1's left and right great toenail fungus.</p> <p>During an interview on 9/16/2025 at 12:58 p.m., with the Director of Nursing (DON) the DON stated it was important to follow and carry out physician's orders because it was part of the care of the residents to promote healing. The DON stated there was a possibility of causing a delay of care or slowing the progression of healing for missing an order for medication. The DON stated it was important to obtain a copy of the Office Visit Notes within 72 hours to ensure all recommendations and orders were followed through and carried out.</p> <p>During a review of the facility's Registered Nurse Job Description dated 12/17/2021, the job description indicated the Registered nurse was responsible for initiating requests for consultations and referrals and responding to requests from the resident, physician, or nursing staff. Registered Nurses job responsibilities included consulting with the physicians regarding resident evaluation and planning and developing the nursing services to be performed for the resident. The Registered Nurse job responsibilities included reviewing medication orders for completeness of information and accuracy in the transcription of the physician's order.</p>		