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	02/05/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the necessary care and services for one of 11 sampled residents (Resident 2) by failing to:1. Ensure Resident 2 was monitored and reassessed for a fever with temperature of 100.1.2. Ensure Acetaminophen (medication used for fever) 325mg (mg-metric unit of measurement) tablets oral were administered as ordered.These failures placed Resident 2 at risk for increased fever, dehydration and the potential to lead to infection and a decline in medical status. Findings:During a review of Resident 2's admission Record, the admission record indicated the Resident was admitted to the facility on [DATE] with the diagnoses including lack of coordination (impairment in muscle movement, balance, and motor control), dysphagia oropharyngeal phase, (a swallowing disorder caused by difficulty transferring food from the mouth to the esophagus), urinary retention (is the inability to fully empty the bladder).During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 01/31/2026, the MDS indicated, Resident 2's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required setup or clean- up assistance (helper sets up, resident completes activity) from staff with eating, oral hygiene, and personal hygiene.During a review of Resident 2's vital sign record dated 02/04/2026 at 23:40 pm, the vital sign record indicated Resident 2 had a fever of 100.1 degrees Fahrenheit (F) recorded.During a review of Resident 2 Order Summary report dated 01/27/2026, the Order Summary report indicated Resident 2 had an order for Acetaminophen 325 mg two tablets by mouth every six hours as needed for fever greater than 100 degrees. There was no documentation for temperature monitoring or reassessment.During an interview and record review on 02/05/2026 at 2:40 p.m. with License Vocational Nurse (LVN) 2, LVN 2 stated Resident 2's temperature was elevated from the previous shift. LVN 2 stated it is the responsibility of the Licensed Nurse to monitor any change of condition and elevated temperatures of residents to see if the temperature went down and to give medication as ordered. LVN 2 stated she took Resident 2's temperature and did not have time to document the temperature. LVN 2 stated she will monitor the temperature for residents that has change of condition.During an interview on 02/05/2026 at 3: 36 p.m., with the Director of Nursing (DON), the DON stated the licensed staff on duty failed to give the Acetaminophen medication for the fever. The DON stated licensed staff should assess, give medication as ordered and continue monitoring for fever.During a review of the facility Policy and Procedure (P&P) dated 04/2025. titled, Change of condition/Quality of Care, the P&P indicated, the nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. The P&P indicated the resident will then be placed on the 24-Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions

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: 055894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services for two of two sampled residents (Resident 1 and Resident 2) by failing to administer 9 a.m. medications one hour before or after the scheduled time.This deficient practice placed Resident 1 and Resident 2 at risk for increased adverse drug reactions, increased symptoms and mismanagement of the medication regimen.Findings:1. During a review of Resident 1's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 1 was original admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included Type 2 diabetes with circulatory complications (involve damage to large and small blood vessels caused by chronic high blood sugar, inflammation, and atherosclerosis), hypertension (high blood pressure), dysphagia (difficulty swallowing).During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/24/2025, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making were severely impaired. The MDS indicated Resident needed substantial/maximal assistance - (Helper does more than half the effort) with eating, oral hygiene, and personal hygiene.During a review of Resident 1's Order Summary Report dated 02/2026, the Order Summary Report indicated Resident 1 had orders to receive the following medications:1. Aspirin (decreases inflammation and inhibits blood clotting 81milligrams (mg - unit of measurement) one time a day.2. Ferrous Gluconate (medication to prevent iron-deficiency) 324 mg one time a day.3. Furosemide (medication to reduce excess fluid from the body 20 mg (one time day.4. Metoprolol (medication used to treat high blood pressure) 50 mg one time a day.5. Multivitamin (medication to provide essential vitamins and minerals) one time a day.6. Tamiflu (medication to antiviral medication used to treat and prevent influenza A and B) 75 mg two times a day for influenza until 02/09/2026.7.Spironolactone 25 mg (medication to remove excess fluid) 0.5 one time a day.8. Sacubitril-Valsartan (medication to reduce the risk of heart failure) 24-26 mg two times a day.During a review of Resident 1's Medication Audit Report dated 02/05/2026, the audit report indicated all medication was administered to Resident 1 as follows:1. On 02/02/2026-Aspirin 81mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).2. On 02/02/2026-Ferrous Gluconate 324 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).3. On 02/02/2026-Furosemide 20 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).4. On 02/02/2026-Multivitamin one tablet was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).5. On 02/02/2026-Tamiflu 75 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).6. On 02/02/2026-Spironolactone 25 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).7. On 02/02/2026-Metoprolol 50 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose).8. On 02/02/2026-Sacubitril-Valsartan Oral Tablet 24-26 mg was scheduled to be administered at 9 a.m. but was administered to Resident 1 at 11:27 a.m. (over 1 hour 27 minutes after the scheduled dose). 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included lack of coordination (impairment in muscle movement), dysphagia oropharyngeal phase, (a swallowing disorder caused by (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	02/05/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	difficulty transferring food from the mouth to the esophagus, often resulting from neurological issues), urinary retention (the inability to fully empty the bladder).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required setup or clean- up assistance (helper sets up, resident completes activity) from staff with eating, oral hygiene, and personal hygiene.During a review of Resident 2's Order Summary dated 02/2026, the Order Summary Report indicated, Resident 2 was to receive the following medications:1.Tamiflu 30 mg two times a day for influenza.During a review of Resident 2's Medication Audit Report 2/5/2026, the audit report indicated Resident 2 was administered the following medications:1. On 02/02/2026 - Tamiflu 30 mg was scheduled to be administered at 9 a.m. but was administered to Resident 2 at 11:37 a.m. (over 1 hour 37 minutes after the scheduled dose).During an interview on 02/05/2026 at 2:04 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated medication should be given one hour before and hour after. LVN 1 stated she had multiple things to do, that is why she was behind with the medication administration pass. LVN 1 stated she will call for assistance next when she is behind with passing medications because this would interfere with medication administration time.During an interview on 02/05/2026 at 2:40 p.m. with LVN 2, LVN2 stated Resident 2 medication was not given on time because the pharmacy delayed delivering the medication for Resident 2. LVN 2 stated, she knew it was her duty to follow up with the pharmacy if the medication was not delivered on time.During an interview on 02/05/2026 at 3: 36 p.m., with the Director of Nursing (DON), the DON stated scheduled medications should be given 1 hour before and 1 hour after the scheduled time. The DON stated it was important to administer medications as scheduled to ensure effectiveness and minimize the side-effects. The DON stated staff should ask for help when they are behind but will give an in-service again to make sure staff call for assistance.During a review of the facility's dated 01/2017. policy and procedure (P&P) titled, Medication Administration -General Guidelines, the P&P indicated, Medications are administered in a safe and timely manner, as prescribed. The P&P also indicated medications are administered within (60 minutes) of scheduled time, unless otherwise specified by prescriber.