

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 11/08/2024
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility failed to conduct the quarterly Interdisciplinary Team (IDT-team of health care professionals that work together toward and prioritize the resident 's needs) care conference involving one of three sampled resident's (Resident 25) Family Member 1 (FM 1).</p> <p>This deficient practice violated Resident 25 and FM 1's rights to be informed and the right to participate in resident's plan of care.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] with diagnoses including type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 25's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/16/2024, the MDS indicated Resident 25's cognition was severely impaired. The MDS indicated Resident 25 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a phone interview on 11/6/2024 at 9:41 a.m., with FM 1, FM 1 stated the facility staff used to tell the family everything about the resident and residents care and had IDT team meetings every three months and then it stopped. FM 1 stated she does not remember when the last IDT meeting was.</p> <p>During an interview and record review on 11/6/2024 at 2:57 p.m. with Registered Nurse (RN)1 Resident 25's IDT Care Conferences were reviewed, and the last IDT Care Conference documented was on 11/14/2023. RN 1 confirmed and stated Resident 25's IDT care conference was overdue. RN 1 stated IDT meetings were important so the family will be updated on treatments and care plans and so the family can help develop goals.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. with the Director of Nursing (DON), the DON stated IDT care conferences were completed on admission and quarterly, so family was aware and involved in the residents' plan of care.</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 0553</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, Comprehensive resident centered Care Plan, revised 2/2023, the P&P indicated to the extent possible the resident, resident's family and/or responsible party should participate in the development of the care plan. The P&P indicated every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party. A summary of the IDT Care Plan review shall be documented in the IDT Care Plan review.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144</p> <p>Based on observation, interview and record review, the facility's interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together) failed to ensure that a resident was assessed to determine if the resident is capable to self-administer medications for one of one sampled resident (Resident 69).</p> <p>This deficient practice had a potential for resident to self-administer respiratory medications incorrectly resulting in subtherapeutic (below the level necessary to treat effectively) medication effects which can lead to unresolved wheezing (caused by narrowing or blocked airways in the lungs) or difficulty breathing.</p> <p>Findings:</p> <p>During a review of Resident 69's Admission Record, the record indicated Resident 69 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of asthma (a chronic lung disease that causes the airways to narrow and swell, making it difficult to breathe) and allergic rhinitis (condition that causes sneezing, congestion, and sore throat),</p> <p>During a review of Resident 69's History and Physical (H&P), dated 4/25/2024, the H&P indicated resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 8/22/2024, the MDS indicated Resident 69 was independent for eating and oral hygiene, required setup or assistance for personal hygiene, and required partial/moderate assistance (helper does less than half the effort) for showering and lower body dressing.</p> <p>During a review Resident 69's Order Summary Report, dated 11/7/2024, the document indicated, orders for:</p> <p>a. Azelastine HCl Nasal Solution 137 mcg/spray (azelastine HCl) 2 spray in each nostril two times a day for Rhinitis allergy. Order date 4/22/2024.</p> <p>b. Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg/act (Tiotropium Bromide Monohydrate) 2 puff inhale orally one time a day related to unspecified asthma. Order date 4/22/2024.</p> <p>c. Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puff inhale orally two times a day related to unspecified asthma. Order date 4/22/2024.</p> <p>During an observation on 11/6/2024 at 9:10 a.m. at Resident 69's room, Licensed Vocational Nurse (LVN) 2 handed Resident 69 the Azelastin nasal spray, the Spiriva inhalation solution, and the Symbicort inhalation aerosol. Resident 69 was observed self-administering all 3 medications.</p> <p>During an interview with the medical records director (MRD) on 11/7/2024 at 10:00 a.m., the MRD stated there was no documentation to indicate Resident 69 was assessed to determine if the resident is a candidate to self-administer medication.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) interim on 11/8/2024 at 12:45 p.m., the DON interim stated nasal sprays and inhaled medications should be administered by the nurse to ensure the resident receives the correct dose. The DON interim stated if a resident who has not been assessed to self-administer medications, administers their own medication, the medication may be given incorrectly and will not be effective.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines - Self-Administration of Medications, revised 1/2017, the P&P indicated, Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and the result of the assessment are recorded in the resident's medical record. The P&P indicated for each medication authorized for self-administration, the label contains a notation that it may be self-administered.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 25) was assessed for use and received informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), and physician order for Resident 25's bolster (long pillows at the foot of the bed).</p> <p>The deficient practice resulted in a violation of resident rights to be free from restraints (any manual method, physical or mechanical device, equipment, or material that is adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement).</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] with diagnoses including type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 25's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/16/2024, the MDS indicated Resident 25's cognition was severely impaired. The MDS indicated Resident 25 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During an observation and interview on 11/6/2024 at 3:00 p.m. at Resident 25's bedside with Registered Nurse (RN)1, Resident 25 was observed to have bolsters at the foot of the bed and side rails (barriers attached to the side of a bed) at the top of the bed. RN 1 stated the siderails and the bolsters restrict residents' free movement to get out of the bed and can be considered a restraint. RN 1 stated restraints need a quarterly assessment and informed consent.</p> <p>During an observation and interview and record review on 11/6/2024 at 3:00 p.m. with RN1 Resident 25's medical records were reviewed, and the records indicated the siderails had orders, an assessment, and informed consent but the bolsters on the bottom part of the bed did not have a physician order, quarterly assessment, and informed consent.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. with the Director of Nursing (DON), the DON stated if a resident had a restraint, a device preventing freedom to be able to move or get out easily the restraining device need a consent, assessment, and a physician order.</p> <p>(continued on next page)</p>		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Care and Treatment: Physical Restraints revised 2/2023, the P&P indicated Physical Restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Physical restraints may include siderails or any device that keep a resident from voluntarily getting out of bed. The P&P indicated residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. The P&P indicated restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor).		

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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** 44055</p> <p>Based on interview and record review, the facility failed to report one of one resident's (Resident 25) unknown injury to the California Department of Public Health (CDPH), when Resident 25 was observed with left lower leg bent inward towards the resident possibly indicating fracture (broken bone) on 2/9/2023.</p> <p>This deficient practice resulted in CDPH's inability to investigate the report of unknown injury timely and had the potential for other cases of unknown injuries to go unreported.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] with diagnoses including type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), Dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left ankles and knees.</p> <p>During a review of Resident 25's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/16/2024, the MDS indicated Resident 25's cognition was severely impaired. The MDS indicated Resident 25 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 25's Change in Condition evaluation, dated 2/9/2023 at 8:30 p.m., the form indicated at approximately 8:30 p.m. the certified nurse assistant (CNA) reported to the supervisor the Resident 25's left lower leg appeared abnormally bent, supervisor confirmed left lower leg bent inward towards the resident possibly indicating fracture.</p> <p>During a review of Resident 25's General acute care hospital (GACH) Emergency Department (ED) Notes, dated 2/8/2023 at 9:56 p.m., the notes indicated Resident 25 was nonverbal with advanced dementia, at the GACH ED for obvious deformity of left lower extremity discovered by staff and no history of trauma. ED note indicated social work consult done due to unexplained injury at nursing home.</p> <p>During an interview on 11/7/2024 at 12:05 p.m., the ADMIN stated he did not report the incident because he did not think it was reportable.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. the current interim Director of Nursing (DON), the DON stated unknown injuries need to be reported within time frame required by law.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention of and Prohibition Against, revised 12/2023, the P&P indicated injuries of unknown source is used to classify an injury when all the following criteria are met:</p> <p>a. the source of the injury was not observed by any person; and</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>b. the source of injury could not be explained by the resident; and</p> <p>c. the injuries suspicious because of the extent the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time.</p> <p>Because some cases of abuse are not directly observed understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include but are not limited to injuries of unknown source, extensive injuries, and injuries in an unusual location. All reports of resident abuse (including injuries of unknown origin) are reported to local, state, and federal agencies (as required by current regulations).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility failed to investigate one of one resident's (Resident 25) unknown injury after Resident 25 was observed with the left lower leg bent inward towards the resident possibly indicating a fracture (broken bone) on 2/9/2023 and report the results of the investigation to the California Department of Public Health (CDPH) within five working days of the incident.</p> <p>This deficient practice resulted in CDPH's inability to investigate the report of unknown injury timely and had the potential for other cases of unknown injuries to go unreported.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] with diagnoses including type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), Dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left ankles and knees.</p> <p>During a review of Resident 25's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/16/2024, the MDS indicated Resident 25's cognition was severely impaired. The MDS indicated Resident 25 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 25's Change in Condition evaluation, dated 2/9/2023 at 8:30 p.m., the form indicated at approximately 8:30 p.m. the certified nurse assistant (CNA) reported to the supervisor the Resident 25's left lower leg appeared abnormally bent, supervisor confirmed left lower leg bent inward towards the resident possibly indicating fracture.</p> <p>During a review of Resident 25's General acute care hospital (GACH) Emergency Department (ED) Notes, dated 2/8/2023 at 9:56 p.m., the notes indicated Resident 25 was nonverbal with advanced dementia, at the GACH ED for obvious deformity of left lower extremity discovered by staff and no history of trauma. The ED note indicated social work consult done due to unexplained injury at nursing home.</p> <p>During an interview on 11/7/2024 at 12:05 p.m., the ADMIN stated he did not report the incident because he did not think it was reportable and the ADMIN stated there was no documented evidence of the investigation completed by the previous Director of Nursing.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. the current interim Director of Nursing (DON), the DON stated unknown injuries need to be reported within time frame required by law.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention of and Prohibition Against, revised 12/2023, the P&P indicated injuries of unknown source is used to classify an injury when all the following criteria are met:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. the source of the injury was not observed by any person; and</p> <p>b. the source of injury could not be explained by the resident; and</p> <p>c. the injuries suspicious because of the extent the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time.</p> <p>Because some cases of abuse are not directly observed understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include but are not limited to injuries of unknown source, extensive injuries, and injuries in an unusual location.</p> <p>1. All reports of resident abuse (including injuries of unknown origin) are reported to local, state, and federal agencies (as required by current regulations).</p> <p>2. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.</p> <p>3. The investigation will include the following:</p> <p>a. An interview with the person(s) reporting the incident;</p> <p>b. An interview with the resident(s);</p> <p>c. Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate;</p> <p>d. A review of the resident's medical record;</p> <p>e. An interview with staff members (on all shifts) who may have information regarding the alleged incident;</p> <p>f. Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident;</p> <p>g. An interview with staff members (on all shifts) having contact with the accused employee; and</p> <p>h. A review of all circumstances surrounding the incident.</p> <p>4. At the conclusion of the investigation, the Facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation has occurred.</p> <p>5. The investigation, and the results of the investigation, will be documented.</p> <p>6. All phases of the investigation will be kept confidential in accordance with the Facility's policies governing the confidentiality of medical records and privilege of quality assurance/ quality improvement programs.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review the facility failed to ensure one of three sampled resident's (Resident 55) Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder -MD- are placed in facilities that can provide the appropriate care) screening was completed upon readmission on 7/1/2023.</p> <p>This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 55.</p> <p>Findings:</p> <p>During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 55's Minimum Data Set (MDS - a resident assessment tool), dated 9/20/2024, the MDS indicated Resident 55s cognition was moderately impaired.</p> <p>During an interview and record review on 11/7/2024 at 8:56 a.m. with Assistant Director of Nursing (ADON) Resident 55's admission record was reviewed and the ADON confirmed Resident 55 had mental illness diagnosis of schizoaffective disorder and bipolar disorder. The ADON stated based on Resident 55's diagnoses it indicated Resident 55 needed a Level II PASARR. The ADON stated Resident 55 was readmitted from the hospital on 7/1/2023 and an updated PASSAR level 1 should have been completed.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. with the Director of Nursing (DON), the DON stated PASARR should be accurate and completed as required by law.</p> <p>During a record review of the facility's policy and procedure (P&P) titled, Preadmission Screening & Resident Review (PASRR) Policy, revised 2/2023, the P&P indicated it was the policy of this facility to ensure that each resident was properly screened using the PASRR specified by the State. PASRR shall be completed in every resident upon admission. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with Intellectual disability or related condition or serious mental illness.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144</p> <p>Based on observation, interviews and record review, the facility failed to initiate a care plan for the Restorative Nursing Assistant ([RNA] assist the patient in performing tasks that restore or maintain physical function as directed by the established care plan) for splinting (a technique that uses a device to immobilize (prevent movement) a joint or limb to help with pain control, injury stabilization, and/or tissue healing) for one out of two residents (Resident 31).</p> <p>This deficient practice had the potential to negatively affect the delivery of necessary care and services including skin breakdown, pain, or harm to the resident.</p> <p>Findings:</p> <p>During a review of Resident 31's admission record, the admission record indicated Resident 31 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain) and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right hand.</p> <p>During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool) dated 7/29/2024, the MDS indicated Resident 31 had moderately intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and had an impairment on one side of his upper extremities (involving arms or hands).</p> <p>During a record review of Resident 31's history and physical (H&P) dated 8/6/2024, the H&P indicated Resident 31 had the capacity to understand and make decisions.</p> <p>During a record review of Resident 31's physician orders dated 10/8/2024, the physician orders indicated Resident 31 had orders for RNA Program: Sit to stand with grab bar (a safety device that provides support and stability to help maintain balance) as tolerated three times a week every day shift ordered on 10/1/2024.</p> <p>During concurrent observation and interview in on 11/5/2024 at 11:51 a.m., in Resident 31's room, Resident 31 was wearing a splint on right hand. Resident 31 stated the RNA helps him put on the splint.</p> <p>During an observation on 11/6/2024 at 10:00 a.m. in Resident 31's room, Resident 31 was wearing a splint on right hand.</p> <p>During an observation on 11/7/2024 at 1:10 p.m. in the smoking patio, Resident 31 was wearing a splint on right hand.</p> <p>During an observation on 11/8/2024 at 12:19 p.m. in Resident 31's room, Resident 31 was wearing a splint on right hand.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/8/2024 at 1:34 p.m., Resident 31's RNA's flowsheets were reviewed with Restorative Nurse Assistant (RNA) 3. RNA 3 stated they performed sit-to-stand exercises as ordered and applied Resident 31's splint every day. RNA 3 stated there is no order for the splint at this time. RNA 3 stated there should be an order to apply the splint before any RNA applies a splint to a resident.</p> <p>During a concurrent interview and record review on 11/8/2024 at 2:00 p.m. with Occupational Therapist (OT) 1, Resident 31's orders were reviewed. OT 1 stated there is no order or care plan for an RNA to apply a splint to Resident 31. OT 1 stated RNA's cannot apply a splint without an order. OT 1 stated it is important to have an order and care plan to apply a splint because it includes details such as the frequency and length of time the splint should be applied to a resident. OT 1 stated if there is no order or care plan for a splint and it is being applied to a resident, there is a risk for incorrect application placing the resident at risk for skin breakdown.</p> <p>During an interview on 11/8/2024 at 11:50 p.m., with the interim (temporary) Director of Nursing (DON), the interim DON stated that care plans and orders are required for an intervention such as applying splints to a resident. The interim DON stated the risk of not initiating a care plan could result in not knowing whether the resident's condition is improving or declining.</p> <p>During a review of facility's policy and procedures (P&P) dated November 2016 and revised in December 2023, titled Comprehensive Person-Centered Care Planning, the P&P indicated a comprehensive person-centered care plan shall be developed 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.</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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50387</p> <p>Based on observation, interview, and record review, the facility failed to monitor and monitor and document the condition of a suprapubic (a urinary catheter that is inserted into the bladder [a hollow organ that stores urine] from a small cut in the lower area of the stomach) catheter (a flexible tube inserted into an opening in the body) stoma (a surgical hole) site for signs and symptoms of infection, skin breakdown, unusual odor, and secretions. as ordered by the physician for one of two residents (Resident 61).</p> <p>This deficient practice has the potential to delay the detection of early signs or symptoms of infection.</p> <p>Findings:</p> <p>During a review of Resident 61's Admission Record, the Admission Record indicated the facility admitted Resident 61 on 5/9/2024 and readmitted him on 7/19/2024 with diagnoses including urinary tract infection (an infection in any part of the urinary system), and obstructive reflux uropathy (UTI-condition that affect the urinary tract and can cause urine to flow abnormally).</p> <p>During a review of Resident 61's Minimum Data Set (MDS-a resident assessment tool), dated 8/12/2024, the MDS indicated Resident 61's cognitive (the ability to think and process information) skills for daily decision making were severely impaired.</p> <p>During a review of Resident 61's History and Physical (H&P), dated 7/24/2024, the H&P indicated, Resident 61's assessment was 1. Sepsis (a serious condition in which the body responds improperly to an infection) & UTI, operation: Suprapubic catheter.</p> <p>During a review of Resident 61's Order Summary Report, active orders as of 11/8/2024, the Order Summary Report indicated an order on 8/7/2024 to monitor the suprapubic catheter stoma site for signs and symptoms (S/S) of infection, skin breakdown, pain, discomfort, unusual odor, urine characteristics, secretions, catheter pulling causing tension, to notify the primary physician if S/S exist.</p> <p>During a review of Resident 61's untitled care plan for status post (after a certain event) suprapubic catheter replacement/change, initiated on 8/27/2024, the care plan indicated, a goal for Resident 61 to show no signs or symptoms of urinary infection. The target date for the care plan was by 11/11/2024.</p> <p>During a concurrent observation of wound dressing change and interview on 11/7/2024 at 9:10 a.m., with Licensed Vocational Nurse (LVN) 1, in Resident 61's room, LVN 1 was changing the dressing on Resident 61's suprapubic catheter site. LVN 1 stated, the suprapubic catheter site had a bit of redness, discharge, and blood clots (gel-like clumps of blood) around the suprapubic catheter site. LVN 1 stated, she was not sure if her observations of the suprapubic catheter site were healthy or not. LVN 1 stated she would report the findings to the physician and document them.</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 a concurrent interview and record review on 11/7/2024 at 10:07 a.m. with Resisted Nurse (RN) 1, Resident 61's neurology note was reviewed. RN 1 stated, Resident 61 was initially admitted with a foley catheter (a thin, flexible tube that's inserted into the bladder to drain urine when someone can't urinate on their own) on 5/9/2024 then changed to a suprapubic catheter on 7/31/2024 at a General Acute Care Hospital (GACH). LVN 1, stated that staff are expected to update skin assessment notes weekly based on when they change dressings on the suprapubic sites.</p> <p>During an interview on 11/7/2024 at 3:31 p.m., with RN 1, RN 1 stated that checking the suprapubic catheter insertion site and assessing for s/s of infection on Resident 1's suprapubic catheter is important, if it is a possible infection or injury is not identified early, it could cause lead to trauma, injury, infections, and skin injury.</p> <p>During a concurrent interview and record review on 11/8/2024 at 12:40 p.m. with the DON, Resident 61's Treatment Administration Record (TAR) for the month of November was reviewed. The DON stated, it's important to monitor insertion sites after a surgical procedure for signs or symptoms of infection or changes. The DON stated that Resident 61's TAR did not indicate staff were monitoring the insertion sites for s/s of infection or injury.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility failed to ensure a resident, who was assessed at a moderate risk for developing a skin injury and had intact skin upon admission, did not develop a Stage III (full thickness tissue loss - underlying fat tissue may be visible, but bone, tendon, or muscle is not exposed) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on the sacro-coccyx area (tailbone) measuring nine centimeters [(cm) unit of measurement] in length, nine cm in width and 0.1 cm in depth for one of two sampled residents (Resident 40). The facility failed to:</p> <ol style="list-style-type: none"> 1. Implement Resident 40's (untitled) care plan intervention to turn and reposition the resident every two hours, to prevent the resident from developing a pressure injury by relieving the pressure from the sacro-coccyx area. 2. Implement the facility's policy and procedure (P&P) titled, Skin and Wound Monitoring and Management revised 12/2023, that indicated in order to prevent the development of skin breakdown/pressure injuries to reposition the resident. <p>These deficient practices resulted in Resident 40 developing a facility-acquired, preventable, Stage III pressure injury on the sacro-coccyx area measuring nine cm in length, nine cm in width and 0.1 cm in depth. The wound had scant serosanguinous (contains or relates to both blood and the liquid part of blood - serum) exudate (fluid that leaks out of blood vessels into nearby tissues) with 20 percent (%) slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) and 80 % epithelial (appears pink or pearly white, and wrinkles when touched, occurs in the final stage of healing) tissue.</p> <p>Findings:</p> <p>During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of greater trochanter of right femur (hard area on the outside of the hip), age related osteoporosis (a disease that causes bones to become weak and more likely to break) with pathological (caused by disease) fracture, type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), abnormal posture, need for assistance of personal care, difficulty of walking, and lack of coordination.</p> <p>During a review of Resident 40's Minimum Data Set ([MDS], a resident assessment tool), dated 7/12/2024, the MDS indicated Resident 40's cognitive skills (ability to think and reason) for daily decision-making were moderately impaired. The MDS indicated Resident 40 required partial assistance (helper does less than half the effort helper lifts support or holds trunk or limbs but provides less than half the effort) with toileting hygiene and rolling left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 40 was at risk for developing pressure injuries. The MDS indicated Resident 40 did not have pressure ulcers or any unhealed pressure injuries. The MDS indicated Resident 40's skin was intact and did not have any ulcers, wounds, and skin problems.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 40's Braden Scale (a scoring tool used to predict residents' risk of developing a pressure injury, total scores range from 6 - 23. A lower score indicating a higher risk of developing a pressure injury) assessment, dated 7/11/2024, the Braden Scale assessment indicated Resident 40's score was 14 indicating Resident 40 was at moderate risk for developing a pressure injury. The Braden Scale indicated Resident 40's skin was often moist, the resident was chairfast (capable of maintaining a sitting position but lacking the capacity of bearing own weight), had very limited mobility, was unable to make frequent or significant positional changes independently and required moderate to maximum assistance when moving.</p> <p>During an interview on 11/5/2024 at 10:16 a.m., with Resident 40, Resident 40 stated he had a wound on his buttocks area because the facility staff left him sleeping on one side for too long. Resident 40 stated that facility staff did not reposition him to take the pressure off his buttocks area.</p> <p>During an interview and record review on 11/6/2024 at 3:13 p.m., with Registered Nurse (RN 1), Resident 40's Licensed Nurses Skin Evaluation - PRN (as needed)/weekly, dated 9/29/2024 was reviewed the Licensed Nurses Skin Evaluation indicated Resident 40's skin had no redness, bleeding, or open skin areas noted upon assessment. RN 1 confirmed Resident 40's skin was intact on 9/29/2024.</p> <p>During an interview and record review on 11/6/2024 at 3:18 p.m., with RN 1, of Resident 40's Licensed Nurses Skin Pressure Ulcer Weekly documentation, dated 10/8/2024, the Licensed Nurse Skin Pressure Ulcer Weekly documentation indicated Resident 40 had a suspected deep tissue injury ([SDTI]- Non blanching [skin that doesn't fade when pressure is applied to it indicating bleeding under the skin] purple or maroon skin discoloration) pressure injury in the sacro-coccyx area which was not present on admission (1/5/2023), on the MDS dated [DATE], and on the Licensed Nurses Skin Evaluation date 9/29/2024.</p> <p>During an interview and record review on 11/6/2024 at 3:25 p.m., with RN 1, of Resident 40's Licensed Nurse Skin Pressure Ulcer Weekly documentation dated 10/8/2024, the Licensed Nurse Skin Pressure Ulcer Weekly documentation indicated the STD1 measured 9.5 cm by 9.5 cm with no depth, no exudate, and with attached wound edges. RN 1 stated Resident 40 had an STD1 on 10/8/2024, nine days after Resident 40's skin was assessed and was intact.</p> <p>During an interview and record review on 11/6/2024 at 3:28 p.m., with RN 1, Resident 40's Order Summary report as of 11/7/2024, was reviewed and the summary report indicated the following:</p> <p>a. A physician's order dated 10/14/2024, for a nutritional supplement (Nutrition powder to promote wound healing) one time a day for supplement (wound healing) for 30 days one packet with six ounces of fluids.</p> <p>b. A physician's order dated 10/9/2024, for a low air loss mattress (mattress designed to prevent and treat pressure wounds)</p> <p>c. A physician's order dated 10/8/2024, Wound consult until wound resolves.</p> <p>d. A physician's order dated 10/8/2024, for Ascorbic acid (Vitamin C supplement) 500 milligrams by mouth one time a day.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>e. A physician's order dated 10/12/2024, for Medi honey wound/burn dressing external gel (wound dressing to promote healing) apply to Sacro-coccyx topically as needed for stage III pressure injury. Clean with Normal saline (salt and water solution), pat dry, apply Medi honey, apply skin prep to peri wound then cover with dry dressing.</p> <p>f. A physician's order dated 10/8/2024, Pro-Stat Oral liquid (supplement liquid protein for wound healing) give 30 milliliters in the evening.</p> <p>During a continued interview and record review on 11/6/2024 at 3:28 p.m., with RN 1, Resident 40's Order Summary report as of 11/7/2024 RN 1 stated the orders indicated were interventions initiated because of Resident 40's newly developed and identified pressure ulcer.</p> <p>During an interview and record review on 11/6/2024 at 3:40 p.m., with RN 1, Resident 40's untitled care plan initiated on 4/26/2023, and revised on 7/2/2024, was reviewed. This care plan indicated Resident 40 was at risk for impaired skin integrity. The care plan goal indicated Resident 40 would have intact skin, free of redness, blisters (a fluid-filled sac in the outer layer of skin that may be caused by rubbing, or pressure), or discoloration through review, dated on 10/8/2024.</p> <p>During an interview and record review on 11/6/2024 at 3:43 p.m., with RN 1, Resident 40's untitled care plan initiated on 4/26/2023, and revised on 7/2/2024, was reviewed, the care plan interventions included Resident 40 would be encouraged to turn and reposition with assistance as necessary. RN 1 stated the care plan was not updated with new interventions on 10/8/2024 when Resident 40's STDI was identified. RN 1 stated the care plan intervention did not indicate turning and repositioning routinely every 2 hours. RN 1 stated the care plan should be updated and implemented to prevent further pressure injury development.</p> <p>During an interview on 11/7/2024 at 12:14 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 40 developed a preventable, facility acquired pressure ulcer because Resident 40 had impaired mobility and was probably not repositioned every two hours.</p> <p>During an interview and record review on 11/7/2024 at 1:47 p.m., with LVN 1 Resident 40's Documentation Survey Report for September and October 2024, the Turned and Repositioned Task documentation was reviewed. The Turned and Repositioned Task documentation indicated Resident 40 was not turned and repositioned on each shift. LVN 1 stated there was no documented evidence Resident 40 was turned and repositioned every two hours on every shift for the month of September and October.</p> <p>During an interview and record review on 11/8/2024 at 12:30 p.m., with the Director of Nursing (DON), Resident 40's Surgical Consult Note, dated 10/10/2024, was reviewed. The Surgical Consult Note indicated Resident 40 had a wound located in the sacro-coccyx area measuring 9.0 cm in length and 9.0 cm in width and 0.1 cm in depth. The wound had scant serosanguinous exudate with 20 %slough and 80 % epithelial tissue and the wound edge was macerated (skin looks soggy there may be a white ring around the wound that are too moist or have exposure to too much drainage).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 11/8/2024 at 12:36 p.m., with the DON, Resident 40's Surgical Consult Note, dated 10/10/2024, was reviewed. The DON stated repositioning the resident was important to prevent pressure injuries on residents' (in general) skin. The DON stated a resident should not develop a Stage III pressure ulcer while in the facility, but it also depends on the resident's comorbidities (medical diagnoses). The DON stated if the turning and repositioning every two hours was not documented then it was not done. The DON stated care plans should be updated.</p> <p>During a review of Pressure Injury Prevention Points Portable Document Format (PDF) published by the National Pressure Injury Prevention Advisory Panel, copyright 2020, the PDF indicated the following pressure injury prevention points:</p> <ol style="list-style-type: none"> 1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. 3. Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. 4. Continue to reposition an individual when placed on any support surface. 5. Reposition weak or immobile individuals in chairs hourly (www.npiap.com) <p>During a review of the facility's P&P titled, Skin and Wound Monitoring and Management revised 12/2023, the P&P indicated:</p> <ol style="list-style-type: none"> 1. A resident having pressure injury received necessary treatment and services to promote healing, prevent infection, and prevent new avoidable pressure injuries from developing. 2. In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: <ol style="list-style-type: none"> a. Stabilize, reduce, or remove any existing any underlying risks. b. Monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition. c. Reposition the resident. 		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>45382</p> <p>CROSSREFERENCE TO F842</p> <p>Based on observation, interview, and record review, the facility failed to provide treatment and services to one of eight sampled residents (Residents 27) to prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) by failing to provide Resident 27 with Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and mobility) passive ROM (PROM, movement at a given joint with full assistance from another person) exercises, three times a week as ordered.</p> <p>This deficient practice had the potential to cause Resident 1 to have a decline in ROM of both arms, contracture (loss of motion of a joint) development, and a decline in physical functioning such as the ability to eat, dress, and bathe.</p> <p>Findings:</p> <p>a. During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 12/4/2017 with diagnoses including rheumatoid arthritis (chronic autoimmune inflammatory disease that affects the joints) of both hands and osteoarthritis (loss of protective cartilage that cushions the ends of bones).</p> <p>During a review of Resident 27's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/30/2024, for RNA to perform PROM exercises to Resident 27's both arms and apply splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 27's both hands, fingers, and wrists for two to four hours, three times a week.</p> <p>During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 27 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 27 required partial/moderate assistance for upper body dressing, lower body dressing, personal hygiene, and toilet transfers, and set up/clean up assistance for eating, oral hygiene, toileting hygiene, rolling to both sides, and bed to chair transfers. The MDS indicated Resident 27 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand).</p> <p>During an observation and interview on 11/6/2024 at 9:15 a.m., in Resident 27's room, Resident 27 was lying in bed. All the fingers of Resident 27's right hand were fully bent at the knuckles with the middle joints and tips of the fingers fully straight. All the fingers of Resident 27's left hand were fully bent at the knuckles with the middle joint of all fingers in a hyperextended (the extension of a body part beyond its normal limits) position. Resident 27 stated staff assisted with putting splints on both of his hands and did not assist with arm ROM exercises.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of an RNA session on 11/7/2024 at 9:48 am, in Resident 27's room, Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) were standing next to Resident 27 who was seated in a wheelchair next to the bed. RNA 1 applied lotion to Resident 27's both arms, massaged both of Resident 27's hands, and applied splints to Resident 27's both hands. RNA 2 did not provide PROM exercises to Resident 27's both arms. RNA 2 told Resident 27 she would return in four hours to remove both hand splints. RNA 1 and RNA 2 stated the RNA session was complete and only applied splints to Resident 27's both hands because there was no RNA order for ROM exercises for Resident 27's arms.</p> <p>During a concurrent interview and record review on 11/7/2024 at 9:57 a.m., RNA 1 and RNA 2 stated they applied splints to Resident 27's both hands only and did not assist Resident 27 with ROM exercises to both arms because there was no RNA order for ROM exercises. RNA 1 and RNA 2 reviewed Resident 27's RNA orders, dated 9/30/2024, and confirmed Resident 27 had an order for PROM to both arms, three times a week. RNA 1 and RNA 2 stated they did not know Resident 27 had an RNA order for PROM exercises of both arms and thought the RNA order was only for application of both hand splints. RNA 2 stated she should have assisted with PROM to Resident 27's both arms before application of both hand splints but did not. RNA 1 and RNA 2 stated they should have been assisting with PROM to Resident 27's both arms because there was an order but did not because they did not know there was an order.</p> <p>During an interview on 11/7/2024 at 2:34 p.m., the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD stated the Physical Therapists (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapists (OT, licensed professional that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluated the resident's abilities and created an RNA program for the RNAs to carry out. The DSD stated the PTs and OTs created the RNA treatment program and wrote the treatment program in the RNA order for the RNAs to carry out. The DSD stated the RNAs were supposed to implement exactly what the RNA order indicated. The DSD stated if the RNAs did not carry out the RNA treatment program as ordered, it could negatively impact the resident's function, mobility, and ROM.</p> <p>During an interview on 11/8/2024 at 11:50 a.m., the Director of Nursing (DON) stated the purpose of the RNA program was to ensure the residents in the facility were receiving services to maintain their functional abilities, improve mobility, and prevent contractures. The DON stated RNA program activities included assisting residents with ROM exercises, mobility, and feeding. The DON stated the RNA treatment plan was determined by a licensed therapist and implemented by the RNAs. The DON stated the RNAs were supposed to follow exactly what the RNA order indicated. The DON stated if RNAs did not carry out the RNA program such as ROM exercises as ordered, it could potentially negatively impact the residents and lead to contracture development, muscle weakness, and muscle atrophy (decrease in size or wasting away of a body part of tissue).</p> <p>During a review of the facility's Job Description, titled Restorative Nursing Assistant, dated 12/17/2021, the RNA Job Description indicated one of the essential duties and responsibilities of the RNA was to perform restorative and rehabilitative procedures as instructed.</p> <p>(continued on next page)</p>		

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<p>F 0688</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 ROM and Contracture Prevention, dated 2/2023, the P/P indicated it was the facility's policy to ensure residents received services, care, and equipment to assure that every resident maintained and/or improved to his/her highest level of ROM and mobility unless reduction was clinically unavoidable. The P/P indicated the implementation of the program was carried out by the appropriate personnel in skilled rehab, routine therapy, restorative nursing or Certified Nursing Assistant staff.</p> <p>During a review of the facility's P/P, titled Restorative Care, dated 2/2023, the P/P indicated the residents would receive services to attain and maintain the highest possible mental/physical functional status and psychological well-being defined by the comprehensive assessment and plan of care.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview, and record review the facility failed to ensure the Registered Dieticians recommendations to increase the tube feeding (medical procedure that provides nutrition, fluids, to people who are unable to eat or drink safely by mouth) was carried out in a timely manner.</p> <p>This deficient practice had the potential to result in the resident's weight loss which can result in negative health outcomes.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] with diagnoses including type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status.</p> <p>During a review of Resident 25's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/16/2024, the MDS indicated Resident 25's cognition was severely impaired. The MDS indicated Resident 25 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 25's Order Summary as of 11/7/2024, the summary indicated starting 10/23/2024 enteral feed (tube feeding) order two times a day Glucerna 1.5 (type of tube feeding formula) at 50 cubic centimeter (cc) per hour (hr) for 20 hours via enteral pump to provide 1000 milliliters/ 1500 kilocalories (kcal) or until dose limit is met (on at 2 p.m. and off at 10 a.m.).</p> <p>During an observation and interview on 11/5/2024 at 9:54 a.m., at Resident 25's bedside, with Licensed Vocational Nurse 3 (LVN 3), Resident 25's tube feeding was observed to be running at 50 cc/ hr.</p> <p>During an interview and record review on 11/7/2024 at 10:21 a.m. with the Dietary Supervisor (DS) Resident 25's Progress Notes dated 10/24/2024 at 10:15 a.m. was reviewed and the note indicated the Registered Dietician (RD) recommended to increase the tube feeding rate to 60 cc per hr times 20 hours to provide 1200 cc/ 1800 kcal. The DS stated the RD recommendations should be followed and order should be at 60 cc/hr. The DS stated we need to follow the recommendations so the resident will not have any weight loss and so nutritional needs will be met.</p> <p>During an interview on 11/8/2024 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the dietician's recommendations should be followed if the physician agrees to the recommendations.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Nutrition Status management revised 12/2023, the P&P indicated it was the policy of the facility to assess each resident's nutritional status and needs and to ensure all residents maintain acceptable parameters of nutritional status such as body weight. Dietary will monitor the resident's response to the interventions and revise the approaches justifying the interventions.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility failed to ensure one of one resident (Resident 34), who was diagnosed with post-traumatic stress disorder (PTSD - mental health condition that can develop after someone experiences or witnesses a traumatic even), received trauma informed care (a model that aims to provide effective mental health services by considering a person's past experiences with trauma).</p> <p>This deficient practice had the potential to result in resident re-traumatization and can be detrimental for the resident's psychosocial status.</p> <p>Findings:</p> <p>During a review of Resident 34's Admission Record, the record indicated Resident 34 was admitted to the facility on [DATE] with a diagnosis including depression (mental health condition characterized by persistent sadness or loss of interest in activities), and PTSD.</p> <p>During a review of Resident 34's Minimum data Set (MDS), federally mandated assessment tool, dated 10/16/2024, the MDS indicated Resident 34's cognition was moderately impaired, and Resident 34 needed moderate assistance (helper does less than half the effort) with eating and personal hygiene, maximal assistance (helper does more than half the effort) with oral hygiene, and was totally dependent on staff with toileting, showering, and dressing.</p> <p>During an interview and record review on 11/7/2024 at 3:17 p.m. with the Assistant Director of Nursing (ADON), Resident 34's medical records, assessments, care plans were reviewed and there were no trauma informed care plans, no trauma assessment for Resident 34. The ADON perused Resident 34's medical records and there was no documented evidence of the assessment of trauma, identification of triggers that can cause traumatization, and there were no personalized trigger specific interventions addressing Resident 34's PTSD. The ADON stated moving forward they will develop and implement a care plan for Resident 34.</p> <p>During an interview with the Director of Nursing (DON) on 11/8/2024 at 12:30 p.m., the DON stated the nurses need to develop individualized trauma informed care for residents who suffered PTSD, so the nurses know exactly how to take care of the resident. The DON stated PTSD residents should receive trauma informed care and get assessed correctly, so they don't get retraumatized with triggers.</p> <p>(continued on next page)</p>		

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<p>F 0699</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, Behavioral Health Services, revised 12/2023, the P&P indicated it was the policy of this 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. Behavioral health encompasses a resident's whole, emotional and mental well-being, which includes the prevention and treatment of mental and substance use disorders, as well as those with history of trauma and/or PTSD. Trauma survivors will receive culturally competent trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Trauma informed care is a program or system that is trauma informed, realizes the widespread impact of trauma, and understands potential paths for recovery recognizes the signs and symptoms of trauma in clients and responds by fully integrating knowledge about trauma into policies and procedures and practices. And seeks to actively resist re-traumatization. On admission, the nursing staff will review the resident's history of PTSD. Staff will observe resident for any behavior problems. The social service designee will also meet the resident to attempt to identify possible historical events, psychosocial issues. The IDT will ensure that residents with a diagnosis of PTSD receives the appropriate treatment and services. In cases where triggers of a past traumatic event have been identified or disclosed, the care plan will identify triggers, specific interventions to avoid, minimize or decrease the effects and impact of the trigger and the resident.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382</p> <p>Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) programs for two of 9 sampled residents (Resident 27 and 31) were modified by qualified and competent staff.</p> <ol style="list-style-type: none"> For Resident 27, Restorative Nursing Assistant 1 (RNA 1) and Restorative Nursing Assistant 2 (RNA 2) modified Resident 27's RNA program. For Resident 31, RNA 3 modified Resident 31's RNA program independently. <p>This deficient practice placed the residents in the facility at risk for harm and injury and had the potential to result in inaccurate and inappropriate provision of necessary care and services, inaccurate assessments and interventions, and compromised skin integrity resulting in skin breakdown (tissue damage caused by friction, shear, moisture, or pressure).</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 12/4/2017 with diagnoses including rheumatoid arthritis (chronic autoimmune inflammatory disease that affects the joints) of both hands and osteoarthritis (loss of protective tissue that cushions the ends of bones). <p>During a review of Resident 27's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/30/2024, for RNA to perform passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 27's both arms and apply splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 27's both hands, fingers, and wrists for two to four hours, three times a week.</p> <p>During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 27 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 27 required partial/moderate assistance for upper body dressing, lower body dressing, personal hygiene, and toilet transfers, and set up/clean up assistance for eating, oral hygiene, toileting hygiene, rolling to both sides, and bed to chair transfers. The MDS indicated Resident 27 had functional range of motion (ROM, full movement potential of a joint) limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 11/6/2024 at 9:15 a.m., in Resident 27's room, Resident 27 was lying in bed. All the fingers of Resident 27's right hand were fully bent at the knuckles with the middle joints and tips of the fingers fully straight. All the fingers of Resident 27's left hand were fully bent at the knuckles with the middle joint of all fingers in a hyperextended position (the extension of a body part beyond it's normal limits). Resident 27 stated staff assisted with putting splints on both of his hands and did not assist with arm ROM exercises. Resident 27 stated staff assisted with bicycle exercises for his arms and legs about two to three times a week.</p> <p>During an observation of an RNA session on 11/7/2024 at 9:48 a.m., in Resident 27's room, Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) were standing next to Resident 27 who was seated in a wheelchair next to the bed. RNA 1 applied lotion to Resident 27's both arms, massaged both of Resident 27's hands, and applied splints to Resident 27's both hands. RNA 2 did not provide PROM exercises to Resident 27's both arms. RNA 2 told Resident 27 she would return in four hours to remove both hand splints. RNA 1 and RNA 2 stated the RNA session was complete and only applied splints to Resident 27's both hands because there was no RNA order for ROM exercises for Resident 27's arms.</p> <p>During a concurrent interview and record review on 11/7/2024 at 9:57 a.m., RNA 1 and RNA 2 stated they applied splints to Resident 27's both hands only and did not assist Resident 27 with PROM exercises to both arms because there was no RNA order for ROM exercises. RNA 1 and RNA 2 stated they did not assist Resident 27 with PROM exercises, but assisted Resident 27 with the motorized exercise device (for the arms and/or legs to help patients strengthen muscles, improve ROM, and increase endurance) exercises in the afternoon for Resident 27's arms and legs a few times a week per Resident 27's request. RNA 1 and RNA 2 stated the Physical Therapy (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) and/or Occupational Therapist (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) specifically wrote for the motorized exercise device, exercises in the RNA order if it was a part of the RNA program and safe for the resident to do. RNA 1 and RNA 2 reviewed Resident 27's RNA orders and confirmed Resident 27 did not have an RNA order for arm and leg exercises on the motorized exercise device. RNA 1 and RNA 2 stated they assisted Resident 27 with the motorized exercise device, exercises a few times a week because they did not want to deny Resident 27's request. RNA 1 and RNA 2 stated they modified the RNA program independently and did not notify a licensed nurse and/or the Rehabilitation (Rehab) Department but should have. RNA 1 and RNA 2 stated the Rehab Department established the RNA treatment program and modified the program as needed. RNA 1 and RNA 2 stated they were supposed to follow exactly what the RNA order indicated and were not allowed to modify the RNA program because they were not qualified to do so. RNA 1 and RNA 2 stated they should have notified the licensed nurse, Director of Staff Development, and the Rehab director that Resident 27 requested the motorized exercise device exercises and waited for the therapists to re-assess Resident 27 and modify the program as needed but did not. RNA 1 and RNA 2 stated the PT and OT were the only staff qualified to modify the RNA program because they had the training and qualifications to do so. RNA 1 and RNA 2 stated if they did not follow RNA orders and modified the RNA program without the proper qualifications, it could potentially cause harm and/or pain to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 31's admission record, the admission record indicated Resident 31 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain) and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right hand.</p> <p>During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had moderately intact cognition and had an impairment on one side of his upper extremities (involving arms or hands).</p> <p>During a record review of Resident 31's history and physical (H&P) form dated 8/6/2024, the H&P indicated Resident 31 had the capacity to understand and make decisions.</p> <p>During a record review of Resident 31's physician orders dated 10/8/2024, the physician orders indicated Resident 31 had orders for RNA Program: Sit to stand with grab bar as tolerated three times a week every day shift ordered on 10/1/2024.</p> <p>During concurrent observation and interview in on 11/5/2024 at 11:51 a.m., in Resident 31's room, Resident 31 was wearing a splint on the right hand. Resident 31 stated the RNA helps him put on the splint.</p> <p>Resident 31 was observed wearing a splint on the right hand on 11/6/2024 at 10:00 a.m., 11/7/2024 at 1:20 p.m., and 11/8/2024 at 12:19 p.m.</p> <p>During a concurrent interview and record review on 11/8/2024 at 1:34 p.m., Resident 31's RNA's flowsheets were reviewed with RNA 3. RNA 3 stated they performed sit-to-stand exercises as ordered and applied Resident 31's splint every day. RNA 3 stated there is no order for the splint at this time. RNA 3 stated there should be an order to apply the splint before any RNA applies a splint to a resident.</p> <p>During an interview on 11/7/2024 at 2:34 p.m., the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD stated the PT and/or OT established the RNA program, wrote the RNA order, and the RNAs implemented the RNA treatment program as ordered. The DSD stated if an RNA program required modification, the RNA must notify the Director of Rehabilitation (DOR) who in turn would have an OT and/or PT re-assess the resident, modify the RNA program, update the RNA order, and train and discuss any changes in the RNA treatment plan with the RNAs. The DSD stated PT and/or OT were the only staff qualified to modify the RNA program because they had the expertise, training, and qualifications to do so. The DSD stated if RNAs modified the RNA program independently, it could jeopardize the safety of the residents in the facility because they were not licensed and did not have the training and qualification to modify an RNA program.</p> <p>During an interview on 11/8/2024 at 9:53 am, Occupational Therapist 1 (OT) stated PT and/or OT established and modified the RNA program as needed. OT 1 stated specific RNA exercises and equipment were recommended for each resident for a reason based on the therapist's assessment and the resident's functional abilities. OT 1 stated RNAs were supposed to carry out the RNA program as ordered and could not modify the RNA program because they were not qualified to do so. OT 1 stated if an RNA modified the RNA program independently, it could potentially cause harm and injury to the residents in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/8/2024 at 11:50 am, the Director of Nursing (DON) stated the RNA treatment plan was determined by a licensed therapist and implemented by the RNAs as ordered. The DON stated the RNAs were supposed to follow exactly what the RNA order indicated. The DON stated if an RNA program required modification, the RNA must notify a licensed nurse, PT, and/or OT who in turn would re-assess the resident and modify the RNA program if appropriate based on the resident's needs. The DON stated RNAs were not qualified and competent to modify an RNA program because they did not have the proper training and expertise. The DON stated if RNAs modified the RNA program independently, it could negatively impact the safety of the residents and staff in the facility.</p> <p>During a review of the facility's Job Description, titled Restorative Nursing Assistant, dated 12/17/2021, the RNA Job Description indicated one of the essential duties and responsibilities of the RNA was to perform restorative and rehabilitative procedures as instructed.</p> <p>During a review of the facility's Policy and Procedure (P/P), titled Nursing Staff Competency, dated 2/2023, the P/P indicated it was the policy of the facility to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The P/P indicated the competency in skills and techniques necessary to care for residents included basic restorative services.</p> <p>During a review of the facility's P/P, titled ROM and Contracture Prevention, dated 2/2023, the P/P indicated the implementation of the program was carried out by the appropriate personnel in skilled rehab, routine therapy, restorative nursing or Certified Nursing Assistant staff.</p> <p>During a review of the facility's P/P, titled Restorative Care, dated 2/2023, the P/P indicated a resident's restorative care required close intervention and follow-through by physical, occupational, and speech therapists and the nursing department. The P/P indicated all employees would be informed and trained regarding their responsibility and role in resident restorative care. The P/P indicated each resident must be assessed to determine if they can reach a higher level, must be maintained at a current level, or must cope with a declining situation. The P/P indicated following assessment, all information must be integrated with that of other departments at the resident's care planning conference prior to developing or updating the restorative nursing plan.</p> <p>50144</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review the facility failed to ensure:</p> <p>a) a) One of two sampled resident (Resident 60)'s informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for a Seroquel (a psychotropic drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) to treat mental illness was updated.</p> <p>b) One of two sampled resident's (Resident 23) had a medical diagnosis indicated for use of haloperidol (psychotropic).</p> <p>This failure had the potential to for residents to receive unnecessary psychotropic medications which can lead to a risk of increased falls, confusion, or death.</p> <p>Findings:</p> <p>a) During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was originally admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>During a review of Resident 60's History and Physical (H&P), dated 1/20/2024, the H&P indicated Resident 60 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 60's order summary report as of 11/8/2024, the report indicated, starting on 9/10/2024, Seroquel oral tablet, 25 milligrams (MG), give 0.5 tablet by mouth at bedtime for agitation manifested by (m/b) angry outbursts.</p> <p>During a review of Resident 60's order summary report as of 11/8/2024, the report indicated, Seroquel 0.5 tablet of 25 MG was administered every night from 10/1/2024 to 10/31/2024.</p> <p>During a concurrent record review and interview with Licensed Vocational Nurse (LVN) 3, Resident 60's Informed Consent signed on 2/20/2024 was reviewed. LVN 3 stated the Informed Consent dated 2/20/2024 is the most recent updated Informed Consent for Seroquel for Resident 60. LVN 3 stated the Informed Consent is for Seroquel 25 mg give 0.5 tab PO (by mouth) every 12 hours for bipolar disorder manifested by restlessness and agitation. LVN 3 stated Resident 60's monitored behaviors do not match the order that was written on 9/10/2024. LVN 3 stated if the informed consent does not reflect the current orders, the resident can get medications for the wrong reasons and possibly violate the resident's right to refuse the medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Broadway by the Sea		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. Broadway Long Beach, CA 90803	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review and interview with the interim (temporary) Director of Nursing (DON) on 11/8/2024 at 12:45 p.m., Resident 60's Informed Consent signed on 2/20/2024 was reviewed. The interim DON stated the Informed Consent for psychotropic medications are valid for 6 months and should be updated if the order changes.</p> <p>During a review of the All Facilities Letter (AFL - guidance from the California Department of Public Health (CDPH) Center for Health Care Quality (CHCQ) Licensing and Certification (L&C) - A program for health facilities that may include changes in healthcare, enforcement, scope of practice, or general information that affects the health facility) 24-07, dated 2/28/2024, the AFL indicated Facilities must obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and consent renewal every six months.</p> <p>b) During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was originally admitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognition was severely impaired. The MDS indicated Resident 23 needed set up assistance when eating, supervision with oral hygiene, partial assistance (helper does less than half the effort) with personal hygiene and was totally dependent on staff with showering and toileting hygiene.</p> <p>During a review of Resident 23's Order summary report as of 11/7/2024, the report indicated, starting on 2/11/2024, Haloperidol oral tablet, 1 milligram give one tablet by mouth two times a day for schizophrenia (mental health illness a serious mental health condition that affects how people think, feel and behave) manifested by paranoia (unrealistic distrust of others) and delusion (belief or altered reality that is persistently held despite evidence or agreement to the contrary) and stating she has fear others are out to get her.</p> <p>During an interview and record review on 11/7/2024 at 1:58 p.m., with Registered Nurse Supervisor (RN) 1, Resident 23's medical records were reviewed, and RN 1 confirmed and stated Resident 23 did not have a medical diagnosis for taking the Haloperidol ordered. RN 1 stated none of the physician notes indicated a diagnosis of schizophrenia and it was possibly an unnecessary medication that Resident 23 received.</p> <p>During an interview on 11/7/2024 at 12:30 p.m., with the Director of Nursing (DON), the DON stated it was important to order psychotropic such as Haloperidol if a resident has a medical diagnosis that the Haloperidol is to treat to ensure it was not an unnecessary medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Medications, revised/reviewed 12/2023, the P&P indicated it was the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience.</p> <p>50144</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>50144</p> <p>Based on observation, interview and record review, the facility failed to administer medications appropriately for three (Residents 24, 69, and 140) of five residents observed during the medication pass. During medication pass, there was one medication error for Resident 24, one medication error for Resident 69, and five medication errors for Resident 140 for a total of 7 medication errors out of 31 opportunities.</p> <p>These medication administration errors resulted to a medication error rate of 22.58%.</p> <p>Findings:</p> <p>a. During a review of Resident 24's Admission Record, the record indicated Resident 140 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of atherosclerotic heart disease (condition where plaque builds up in the arteries of the heart) and myocardial infarction (MI- heart attack).</p> <p>During a review of Resident 24's History and Physical (H&P), dated 10/25/2024, the H&P indicated resident had the capacity to understand and make decisions.</p> <p>During a review Resident 24's Order Summary Report, dated 11/7/2024, the document indicated, Aspirin Tablet Chewable 81 MG (Milligram - a unit of measurement) Give 1 tablet by mouth one time a day for deep vein thrombosis (DVT - blood clot that forms in a deep vein in the body, usually in the lower leg or thigh) prophylaxis (PPX-prevention). Order date 10/18/2024.</p> <p>During an observation on 11/6/2024 at 8:55 a.m. at Resident 24's bedside, Licensed Vocational Nurse (LVN) 2 prepared and administered Resident 24's medications that included one tablet of aspirin 81 mg. Resident 24 was observed swallowing all medications including the Aspirin 81 mg tablet.</p> <p>During a review of Resident 69's Admission Record, the record indicated Resident 69 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of atherosclerosis of aorta (condition where plaque builds up in the arteries of the heart).</p> <p>During a review of Resident 69's History and Physical (H&P), dated 4/25/2024, the H&P indicated resident had the capacity to understand and make decisions.</p> <p>During a review Resident 69's Order Summary Report, dated 11/7/2024, the document indicated, Aspirin Tablet Chewable 81 MG Give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis (PPX-prevention). Order date 4/22/2024.</p> <p>During an observation on 11/6/2024 at 9:10 a.m. at Resident 69's room, Licensed Vocational Nurse (LVN) 2 prepared and administered Resident 69's medications that included one tablet of aspirin 81 mg. Resident 69 was observed swallowing all medications including the Aspirin 81 mg tablet.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/6/2024 at 9:35 a.m. with LVN 2, LVN 2 stated both Resident 24 and Resident 69 had orders for chewable aspirin, but both Resident 24 and Resident 69 swallowed the aspirin. LVN 2 stated that swallowing the aspirin that should be chewed will affect the where and when the aspirin is absorbed and may not have the intended effect.</p> <p>During an interview with the Director of Nursing (DON) interim on 11/8/2024 at 12:45 p.m., the DON interim stated medications should be administered as ordered. The DON interim stated if resident swallows the chewable aspirin tablet, the aspirin will not be effective as a blood thinner.</p> <p>During a review of the facility's P&P titled, Specific Medication Administration Procedures, revised 1/2017, the P&P indicated, to check the medication administration record (MAR) for order and administer medications in a safe and effective manner.</p> <p>b. During a review of Resident 140's Admission Record, the record indicated Resident 140 was admitted to the facility on [DATE].</p> <p>During a review of Resident 140's Initial Admission record dated 11/5/2024 and timed at 9:40 p.m., the record indicated Resident 140 was alert and oriented to time, place, person, and situation.</p> <p>During an interview on 11/6/2024 at 8:02 a.m., with Resident 140, Resident 140 stated he was in the General Acute Care Hospital (GACH) for two months because he had a stroke (loss of blood flow to a part of the brain) and had a gastrostomy (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube.</p> <p>During a review of Resident 140's Order Summary as of 11/7/2024, the summary indicated, starting 11/5/2024:</p> <ol style="list-style-type: none"> 1. Losartan 100 milligrams (mg) give one tablet via g-tube one time a day for hypertension (HTN-high blood pressure). 2. Olanzapine oral tablet 10 mg, give one tablet via G-tube every 12 hours for psychotic feature (symptoms of psychosis, a condition where someone loses touch with reality) manifested by striking out. 3. Paroxetine oral tablet 20 mg, give one tablet via G-tube once a day for depression (serious mental health condition characterized by a low mood or loss of interest in activities that lasts for a long time and interferes with daily life) manifested by verbalization of feeling depressed. 4. Quetiapine oral tablet 50 mg, give one tablet via G-tube three times a day for mood disorder (any of a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood) manifested by angry outbursts. 5. Carvedilol oral tablet 3.125 mg via G-tube twice a day for HTN. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 11/6/2024 at 8:02 a.m., at Resident 140's bedside, with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed crushing five medications (Losartan, Olanzapine, Paroxetine Quetiapine, and carvedilol) together, dissolving the medications in water, and administering the medications at the same time to Resident 140 via G-tube.</p> <p>During a follow up interview on 11/6/2024 at 10:30 a.m., with LVN 2, LVN 2 stated she should have administered each medication separately to be able to ascertain which medication causes a reaction if any occur.</p> <p>During an interview on 11/8/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated medications should be administered via g-tube one at time, so we know what meds are administered.</p> <p>During a review of the facility's P&P titled, Medication Administration via Feeding tube, revised 1/2022, the P&P indicated, different medications should not be mixed for administration.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 140) was free from significant medication error by failing to ensure Licensed Vocational Nurse (LVN)2 administered five medications individually and not crushed together.</p> <p>This deficient practice potentially resulted in unsafe combinations of medications and had the potential of altering the composition of medications rendering it less effective.</p> <p>Findings:</p> <p>During a review of Resident 140's Admission Record, the record indicated Resident 140 was admitted to the facility on [DATE].</p> <p>During a review of Resident 140's Initial Admission record dated 11/5/2024 9:40 p.m., the record indicated Resident 140 was alert and oriented to time, place, person, and situation.</p> <p>During an interview on 11/6/2024 at 8:02 a.m., with Resident 140, Resident 140 stated he was in the hospital for two months because he had a stroke (loss of blood flow to a part of the brain) and had a gastrostomy (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube.</p> <p>During a review of Resident 140's Order Summary as of 11/7/2024, the summary indicated, starting 11/5/2024:</p> <ol style="list-style-type: none"> 1. Losartan 100 milligrams (mg) give one tablet via g-tube one time a day for hypertension (HTN-high blood pressure). 2. Olanzapine oral tablet 10 mg, give one tablet via G-tube every 12 hours for psychotic feature (symptoms of psychosis, a condition where someone loses touch with reality) manifested by striking out. 3. Paroxetine oral tablet 20 mg, give one tablet via G-tube once a day depression (serious mental health condition characterized by a low mood or loss of interest in activities that lasts for a long time and interferes with daily life) manifested by verbalization of feeling depressed. 4. Quetiapine oral tablet 50 mg, give one tablet via G-tube three times a day for mood disorder (any of a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood) manifested by angry outburst. 5. Carvedilol oral tablet 3.125 mg via G-tube twice a day for hypertension. <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 11/6/2024 at 8:02 a.m. at Resident 140's bedside, with LVN 2, LVN 2 was observed crushing five medications (Losartan, Olanzapine, Paroxetine Quetiapine, and carvedilol) together, dissolving the medications in water, and administering the medications at the same time to Resident 140 via G-tube.</p> <p>During a follow up interview on 11/6/2024 at 10:30 a.m. with LVN 2, LVN 2 stated she should have administered each medication separately to be able to ascertain which medication causes a reaction if any occur.</p> <p>During an interview on 11/8/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated medications should be administered via g-tube one at time, so we know what meds are administered and for resident safety.</p> <p>During a review of the facility's P&P titled, Medication Administration via Feeding tube, revised 1/2022, the P&P indicated, different medications should not be mixed for administration. If administering several medications, administer each one separately. The tube should be flushed with at least 5 milliliters of water between each medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>50144</p> <p>Based on observation, interview and record review, the facility:</p> <p>a. Failed to ensure facility staff 1 did not leave medication on one of three residents (Resident 8)'s bedside table.</p> <p>b. Failed to ensure Resident 12's budesonide (class of medication used to treat inflammation - swelling) had an open date.</p> <p>Findings:</p> <p>a. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), obesity (disorder that involves having too much body fat), unspecified joint contracture (a limitation in the passive range of motion of a joint) and need for assistance with personal care.</p> <p>During a review of Resident 8's Minimum Data Set ([MDS]), a resident assessment tool, dated 10/17/2024, the MDS indicated Resident 8's cognitive skills (ability to think and reason) for daily decision-making were severely impaired. The MDS indicated Resident 8 required supervision with eating and oral hygiene, maximal assistance with (helper does more than half the effort) with showering and personal hygiene and was totally dependent (staff does all the effort) on staff with toileting hygiene.</p> <p>During an observation and interview on 11/4/2024 at 10:15 a.m., at Resident 8's bedside, with Registered Nurse (RN) 1, there was a medicine cup with a white pasty substance with a tongue depressor (a flat smooth wooden stick with rounded edges) stuck in the paste on Resident 8's bedside table.</p> <p>RN 1 stated that the paste looked like medication. RN 1 stated there was no way to identify what medication was in the cup. RN 1 stated the cup with the white paste should not be there because it was not safe.</p> <p>During an interview on 11/8/2024 at 12:30 p.m., with the Director of Nursing (DON), the DON stated leaving medications at residents' bedside was not safe for residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, updated 1/2017, the P&P indicated Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and chronic heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 12's History and Physical (H&P) dated 10/30/2024, the H&P indicated resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's required supervision with eating, personal hygiene, and oral hygiene, and partial assistance with (helper does less than half the effort) with showering and toileting.</p> <p>During a review of Resident 12's Order Summary Report dated 11/8/2024, the Order Summary Report indicated, Budesonide Inhalation Suspension (a mixture of substances designed to be inhaled) 0.5milligrams (mg)/2 milliliters (ml) (Budesonide (Inhalation)) 1 ml inhale orally via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) two times a day for COPD, Administer x 15 minutes.</p> <p>During a concurrent observation, interview, and record review on 11/8/2024 at 11:48 a.m., at the Station 2 AM Cart, with Licensed Vocational Nurse (LVN) 4, there was an opened Budesonide Inhalation foil envelope in a box that had no open date. LVN 4 stated budesonide is good for 14 days after the foil is opened and should be labeled with the open date. The Budesonide Inhalation box instructions indicated that once the foil envelope is opened, use the medication within 2 weeks. LVN 4 stated the open date is important to indicate when the medication is no longer effective.</p> <p>During an interview with the interim (temporary) Director of Nursing (DON) on 11/8/2024 at 12:45 p.m., the interim DON stated that if a medication such as budesonide is given past the manufacture instructions to use within 2 weeks after opened, there is a possibility the resident will not receive an effective dose and symptoms would not be treated</p> <p>.</p> <p>During a review of the facility's P&P titled, Storage of Medications, updated 1/2017, the P&P indicated Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50387</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1.Ensure proper labeling of open dates for seven seasoning containers. 2.Ensure staff wore a hair net properly while handling dishes in the dishwashing area. <p>These deficient practices had the potential to cause food-borne illnesses.</p> <p>Findings:</p> <p>a.During a concurrent observation and interview on 11/5/2024 at 8:55 a.m. with [NAME] 1, in the Kitchen, observed, there were seven seasoning items without open dates on the 1st shelf above the food preparation equipment area. [NAME] 1 stated that the seven seasoning containers did not have the open dates. [NAME] 1 stated that staff need an in-service regarding open dates, and that the items should be marked with the open dates to ensure every food item is used before the expiration dates.</p> <p>b.During a concurrent observation and interview on 11/5/2024 at 8:55 a.m. with [NAME] 1, in the Kitchen, the right side of Dietary Aid (DA) 1' hair was exposed around the right ear. DA1's hair reached DA 1's right shoulder and the left side of DA1's hair exposed was exposed as well. Cook1 stated, that DA 1 needed an in-service for proper use of the hair net. [NAME] 1 stated that hair could fall into tray of food at any time if the hair is not fully covered by a hairnet.</p> <p>During interview on 11/8/2024 at 8:22 a.m., with the Dietary Supervisor (DS), the DS stated, the opened food items should have open dates marked on the container to ensure they are used before their expiration dates. The DS stated, DA 1 should cover her hair, the hair can come out and potentially get into the food.</p> <p>During a review of the facility's Policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, that newly opened food items will need to be closed and labeled with an open date and used by the dated.</p> <p>During a review of the facility's P&P titled, Dress Code, dated 2023, the P&P indicated that proper Dress includes a hair net for hair, if hair is long (over the ears or longer).</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382</p> <p>Based on interview and record review, the facility failed to ensure Joint Mobility Assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs) for three of eight sampled residents (Residents 15, 29, and 34) were completed by a Physical Therapist (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) and/or Occupational Therapist (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities).</p> <ol style="list-style-type: none"> 1. For Resident 15, Occupational Therapy Assistant 1 (OTA 1) performed Resident 15's Quarterly JMA on 7/15/2024. 2. For Resident 29, OTA 1 performed Resident 29's Quarterly JMA on 8/8/2024. 3. For Resident 34, OTA 1 performed Resident 29's Quarterly JMA on 8/30/2024. <p>This deficient practice had the potential to result in inaccurate assessments, inappropriate recommendations for care, harm, and inaccurate provision of care and services.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 15's Admission Record, the Admission Record indicated the facility initially admitted Resident 15 on 1/13/2024 and readmitted the resident on 10/5/2024 with diagnoses including quadriplegia (weakness or paralysis of all four extremities), muscle weakness, and muscle spasms (involuntary contractions of the muscles). <p>During a review of Resident 15's JMA, dated 7/15/2024, signed by OTA 1, the JMA indicated OTA 1 evaluated Resident 15's ROM of both hips, knees, ankles, shoulders, elbows, wrists, and fingers. The JMA indicated Resident 15's ROM declined since the last assessment in both knees and both ankles. The JMA indicated the interventions to address change in ROM was for RNA to focus on ROM of both legs. The JMA indicated for Resident 15 to continue RNA program to optimize ROM and strength required for resident to participate in daily activities of choice.</p> <p>During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 10/9/2024, the MDS indicated Resident 15 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 15 required partial/moderate assistance for eating, oral hygiene, and personal hygiene, substantial/maximal assistance for upper body dressing and rolling to both sides, and was dependent for bathing, lower body dressing, and transfers. The MDS indicated Resident 15 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot).</p> <p>(continued on next page)</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/6/2024 at 4:05 p.m., OTA 1 who was also the Director of Rehabilitation (DOR) stated the facility monitored for changes in the residents ROM by JMAs completed upon admission, quarterly, upon a change of condition, and annually. COTA 1 stated the PT, OT, and OTA 1 completed the JMAs in the facility.</p> <p>During a follow up interview and record review on 11/7/2024 at 3:17 p.m., OTA 1 stated she provided therapy to the residents in the facility as an OTA in addition to her role as a DOR. OTA 1 stated the role of an OTA was to implement the treatment plans established by a supervising OT. OTA 1 stated OTAs were not allowed to perform evaluations, interpret findings, and make recommendations of care independently. OTA 1 stated an OTA was able to contribute to an evaluation, contribute to recommendations of care, and carry out treatment plans established by a supervising OT but cannot perform these tasks independently. OTA 1 stated she performed JMAs for residents in the facility. OTA 1 stated JMAs consisted of an evaluation of a resident's ROM of both arms and both legs, interpretation of the findings, and recommendations of further care based on the results. OTA 1 reviewed Resident 15's Quarterly JMA, dated 7/15/2024, and confirmed she performed the JMA independently. OTA 1 stated she might have collaborated with an OT since Resident 15 had a decline in function in both knees and both ankles but was unsure and did not have documented evidence to indicate a supervising OT was involved in the assessment and recommendation process. OTA 1 reviewed the Occupational Therapy Practice Act (state specific law that outlines the practice of OT within the state) and California Code of Regulations (federal regulations that affects how OT is practiced in various contexts, particularly in relation to federal funding and services) in relation to treatments performed by OTAs and supervision of OTAs and confirmed she was not qualified to perform JMAs independently.</p> <p>During an interview on 11/8/2024 at 9:53 a.m., Occupational Therapist 1 (OT 1) stated the facility monitored for changes in a resident's ROM by JMAs completed upon admission, quarterly, annually, and upon a change of condition. OT 1 stated an OT, PT and/or the DOR who was also an OTA performed the JMAs. OT 1 stated he did not provide supervision to COTA 1 for JMAs performed. OT 1 stated the role of the OTA was to carry out the interventions established by the supervising OT. OT 1 stated it was not within an OTA's scope of practice (set of activities a person licensed to practice as a health professional is permitted to perform) to perform JMAs independently since it involved assessment of a resident's ROM, interpretation of the findings, and recommendations based on the results of the evaluation. OT 1 stated if unqualified staff provided services that were not within their scope of practice, it could lead to potential injury, inaccurate assessments, and inaccurate services provided.</p> <p>During an interview on 11/8/2024 at 11:50 a.m., the Director of Nursing (DON) stated the Rehabilitation (Rehab) Department completed JMAs for all residents upon admission, quarterly, annually, and upon a change of condition to assess for changes in ROM. The DOR stated the purpose of the JMAs was to ensure a resident's ROM was being maintained, to identify any improvements or declines, and to ensure the interventions provided were effective. The DON stated the licensed PTs and OTs performed the JMAs per facility policy. The DON stated an OTA could not perform JMAs because they did not have the training and qualifications to perform assessments and make recommendations independently. The DON stated it was important all staff were qualified and providing care within their scope of practice to ensure accuracy of assessments, appropriate interventions were being provided, resident safety, and maintenance of his/her license.</p> <p>(continued on next page)</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 29's Admission Record, the Admission Record indicated the facility initially admitted Resident 29 on 2/14/2024 and readmitted the resident on 8/21/2024 with diagnoses including a left-hand contracture (loss of motion of a joint associated with stiffness and joint deformity) and muscle weakness.</p> <p>During a review of Resident 29's Quarterly JMA, dated 8/8/2024, signed by OTA 1, the JMA indicated COTA 1 evaluated Resident 29's ROM of both hips, knees, ankles, shoulders, elbows, wrists, and fingers. The JMA indicated there were no changes in Resident 19's ROM since the last assessment. The JMA indicated for Resident 29 to continue RNA program to optimize ROM for Activities of Daily Living (ADL, basic activities such as eating, bathing, and dressing).</p> <p>During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 was severely cognitively impaired. The MDS indicated Resident 29 required partial/moderate assistance for eating and oral hygiene, substantial/maximal assistance for bathing, and rolling to both sides, and was dependent for toileting hygiene, dressing, and transfers. The MDS indicated Resident 29 had functional ROM limitations in one arm (shoulder, elbow, wrist, hand).</p> <p>During an interview on 11/6/2024 at 4:05 p.m., OTA 1 who was also the DOR stated the facility monitored for changes in the residents ROM by JMAs completed upon admission, quarterly, upon a change of condition, and annually. OTA 1 stated the PT, OT, and OTA 1 completed the JMAs in the facility.</p> <p>During a follow up interview and record review on 11/7/2024 at 3:17 p.m., OTA 1 stated she provided therapy to the residents in the facility as an OTA in addition to her role as a DOR. OTA 1 stated the role of an OTA was to implement the treatment plans established by a supervising OT. OTA 1 stated OTAs were not allowed to perform evaluations, interpret findings, make recommendations of care independently. OTA 1 stated an OTA was able to contribute to an evaluation, contribute to recommendations of care, and carry out treatment plans established by a supervising OT but cannot perform these tasks independently. OTA 1 stated she performed JMAs for residents in the facility. OTA 1 stated JMAs consisted of an evaluation of a resident's ROM of both arms and both legs, interpretation of the findings, and recommendations of further care based on the results. OTA 1 reviewed Resident 29's Quarterly JMA, dated 7/15/2024, and confirmed she performed the JMA independently. OTA 1 reviewed the Occupational Therapy Practice Act and California Code of Regulations in relation to treatments performed by OTAs and supervision of OTAs and confirmed she was not qualified to perform JMAs independently.</p> <p>During an interview on 11/8/2024 at 9:53 a.m., OT 1 stated the facility monitored for changes in a resident's ROM by JMAs completed upon admission, quarterly, annually, and upon a change of condition. OT 1 stated an OT, PT and/or the DOR who was also an OTA performed the JMAs. OT 1 stated he did not provide supervision to OTA 1 for JMAs performed. OT 1 stated the role of the OTA was to carry out the interventions established by the supervising OT. OT 1 stated it was not within an OTA's scope of practice to perform JMAs independently since it involved assessment of a resident's ROM, interpretation of the findings, and recommendations based on the results of the evaluation. OT 1 stated if unqualified staff provided services that were not within their scope of practice, it could lead to potential injury, inaccurate assessments, and inaccurate services provided.</p> <p>(continued on next page)</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/8/2024 at 11:50 a.m., the DON stated the Rehab Department completed JMAs for all residents upon admission, quarterly, annually, and upon a change of condition to assess for changes in ROM. The DOR stated the purpose of the JMAs was to ensure a resident's ROM was being maintained, to identify any improvements or declines, and to ensure the interventions provided were effective. The DON stated the licensed PTs and OTs performed the JMAs per facility policy. The DON stated an OTA could not perform JMAs because they did not have the training and qualifications to perform assessments and make recommendations independently. The DON stated it was important all staff were qualified and providing care within their scope of practice to ensure accuracy of assessments, appropriate interventions were being provided, resident safety, and maintenance of his/her license.</p> <p>3. During a review of Resident 34's Admission Record, the Admission Record indicated the facility initially admitted Resident 34 on 3/17/2022 and readmitted the resident on 11/29/2023 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain).</p> <p>During a review of Resident 34's Quarterly JMA, dated 8/30/2024, signed by OTA 1, the JMA indicated OTA 1 evaluated Resident 34's ROM of both hips, knees, ankles, shoulders, elbows, wrists, and fingers. The JMA indicated Resident 34's ROM of the left ankle declined from minimum (75% to 100% of range intact) to moderate (50% to 75% of range intact) and the ROM of the left elbow improved from severe (0% to 25% of range intact) to maximum (25% to 50% of range intact). The JMA indicated the interventions to address the changes in ROM were to focus on passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 34's left leg. The JMA indicated for Resident 34 to continue RNA program to promote ROM needed for participation in daily activities.</p> <p>During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 was moderately cognitively impaired. The MDS indicated Resident 34 required partial/moderate assistance for eating and personal hygiene and was dependent for toileting hygiene, rolling to both sides, and transfers.</p> <p>During an interview on 11/6/2024 at 4:05 pm, OTA 1 who was also the DOR stated the facility monitored for changes in the residents ROM by JMAs completed upon admission, quarterly, upon a change of condition, and annually. OTA 1 stated the PT, OT, and OTA 1 completed the JMAs in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview and record review on 11/7/2024 at 3:17 pm, OTA 1 stated she provided therapy to the residents in the facility as an OTA in addition to her role as a DOR. OTA 1 stated the role of an OTA was to implement the treatment plans established by a supervising OT. OTA 1 stated OTAs were not allowed to perform evaluations, interpret findings, and make recommendations of care independently. OTA 1 stated an OTA was able to contribute to an evaluation, contribute to recommendations of care, and carry out treatment plans established by a supervising OT but cannot perform these tasks independently. OTA 1 stated she performed JMAs for residents in the facility. OTA 1 stated JMAs consisted of an evaluation of a resident's ROM of both arms and both legs, interpretation of the findings, and recommendations of further care based on the results. OTA 1 reviewed Resident 34's Quarterly JMA, dated 8/30/2024, and confirmed she performed the JMA independently. OTA 1 stated she might have collaborated with an OT since Resident 34 had a decline in function in the left ankle but was unsure and did not have documented evidence to indicate a supervising OT was involved in the assessment and recommendation process. OTA 1 reviewed the Occupational Therapy Practice Act and California Code of Regulations in relation to treatments performed by OTAs and supervision of OTAs and confirmed she was not qualified to perform JMAs independently.</p> <p>During an interview on 11/8/2024 at 9:53 am, OT 1 stated the facility monitored for changes in a resident's ROM by JMAs completed upon admission, quarterly, annually, and upon a change of condition. OT 1 stated an OT, PT and/or the DOR who was also an OTA performed the JMAs. OT 1 stated he did not provide supervision to OTA 1 for JMAs performed. OT 1 stated the role of the OTA was to carry out the interventions established by the supervising OT. OT 1 stated it was not within an OTA's scope of practice to perform JMAs independently since it involved assessment of a resident's ROM, interpretation of the findings, and recommendations based on the results of the evaluation. OT 1 stated if unqualified staff provided services that were not within their scope of practice, it could lead to potential injury, inaccurate assessments, and inaccurate services provided.</p> <p>During an interview on 11/8/2024 at 11:50 am, the DON stated the Rehab Department completed JMAs for all residents upon admission, quarterly, annually, and upon a change of condition to assess for changes in ROM. The DOR stated the purpose of the JMAs was to ensure a resident's ROM was being maintained, to identify any improvements or declines, and to ensure the interventions provided were effective. The DON stated the licensed PTs and OTs performed the JMAs per facility policy. The DON stated an OTA could not perform JMAs because they did not have the training and qualifications to perform assessments and make recommendations independently. The DON stated it was important all staff were qualified and providing care within their scope of practice to ensure accuracy of assessments, appropriate interventions were being provided, resident safety, and maintenance of his/her license.</p> <p>During a review of the facility's undated Job Description, titled Occupational Therapy Assistant, the OTA Job Description indicated the OTA assisted the OT by providing rehabilitative therapy upon completion of evaluation and plan of care following all regulatory and clinical practice requirements. The Job Description indicated the OTA reported to the DOR and was supervised by an OT. The Job Description stated one of the OTA's duties and job responsibilities were to adhere to and assure compliance with the Code of Conduct, facility policies and procedures, and all applicable rules, regulations and standards as promulgated by Federal, State, and accrediting agencies or regulating bodies.</p> <p>During a review of the facility's Policy and Procedure (P/P), titled ROM and Contracture Prevention, dated 2/2023, the P/P indicated the implementation of the program was carried out by the appropriate personnel in skilled rehab, routine therapy, restorative nursing or Certified Nursing Assistant staff.</p> <p>(continued on next page)</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P/P, titled Joint Mobility Assessment, issued and revised on 2/2023, the P/P indicated it was the facility's policy to ensure all residents were assessed for joint mobility limitations upon admission and at a minimum of every three months thereafter. The P/P indicated the purpose of the JMA was to determine a resident's ROM for all major joints and to implement plans of care to increase, maintain, or prevent deterioration of joint mobility. The P/P indicated upon admission, each resident would be assessed for limitations in joint mobility by a licensed therapist, using a JMA form. The P/P indicated the therapist would assess each joint for ROM and document the findings on the JMA sheet, date, and update the reassessment and changes. The P/P indicated the information from the JMA would be used to assist in developing and modifying a plan of care, especially in the areas of physical functioning such as positioning, locomotion, and ADLs.</p> <p>During a review of the California Board of Occupational Therapy (2010), Occupational Therapy Practice Act, Business and Professions Code, Division 2, Chapter 5.6, Occupational Therapy, Section 2570.3 (j), the OT Practice Act indicated the Supervision of an occupational therapy assistant means that the responsible occupational therapist shall at all times be responsible for all occupational therapy services provided to the client. The occupational therapist who is responsible for appropriate supervision shall formulate and document in each client's record, with his or her signature, the goals and plan for that client, and shall make sure that the occupational therapy assistant assigned to that client functions under appropriate supervision. As part of the responsible occupational therapist's appropriate supervision, he or she shall conduct at least weekly review and inspection of all aspects of occupational therapy services by the occupational therapy assistant. (1) The supervising occupational therapist has the continuing responsibility to follow the progress of each patient, provide direct care to the patient, and to assure that the occupational therapy assistant does not function autonomously.</p> <p>During a review of the California Code of Federal Regulations (CCR), Division 39, Article 1, 16 CCR S 4182, the CCR indicated the following: (a) The supervising occupational therapist shall determine the occupational therapy treatments the occupational therapy assistant may perform (b) The supervising occupational therapist shall assume responsibility for the following activities regardless of the setting in which the services are provided: (1) Interpretation of referrals or prescriptions for occupational therapy services. (2) Interpretation and analysis for evaluation purposes.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382</p> <p>50144</p> <p>CROSS REFERENCE TO F688</p> <p>Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services provided were accurately documented for two of nine sampled residents (Resident 27 and 31).</p> <p>a. For Resident 27, Restorative Nursing Assistant 1 (RNA 1) and Restorative Nursing Assistant 2 (RNA 2) failed to accurately document passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises provided during RNA sessions in October 2024 and November 2024.</p> <p>b. For Resident 31, RNA 3 failed to accurately document right upper extremity splint application.</p> <p>This deficient practice had the potential to negatively impact the provision of necessary care and services due to the inaccurate reflection of services provided.</p> <p>Findings:</p> <p>During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 12/4/2017 with diagnoses including rheumatoid arthritis (chronic autoimmune inflammatory disease that affects the joints) of both hands and osteoarthritis (loss of protective tissue that cushions the ends of bones).</p> <p>During a review of Resident 27's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/30/2024, for RNA to perform passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 27's both arms and apply splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 27's both hands, fingers, and wrists for two to four hours, three times a week.</p> <p>During a review of Resident 27's October 2024 RNA flowsheet (daily record of RNA services provided for each month), the RNA flowsheet indicated an RNA order for RNA to perform PROM exercises to Resident 27's both arms and apply splints to Resident 27's both hands, fingers, and wrists for two to four hours, three times a week. RNA initials were documented on the following days: 10/3/2024, 10/5/2024, 10/8/2024, 10/10/2024, 10/12/2024, 10/15/2024, 10/17/2024, 10/19/2024, 10/22/2025, 10/24/2024, 10/26/2024, 10/29/2024, and 10/31/2024.</p> <p>During a review of Resident 27's November 2024 RNA flowsheet, the RNA flowsheet indicated an RNA order for RNA to perform PROM exercises to Resident 27's both arms and apply splints to Resident 27's both hands, fingers, and wrists for two to four hours, three times a week. RNA initials were documented on the following days: 11/2/2024, 11/5/2024, and 11/7/2024.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 27 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 27 required partial/moderate assistance for upper body dressing, lower body dressing, personal hygiene, and toilet transfers, and set up/clean up assistance for eating, oral hygiene, toileting hygiene, rolling to both sides, and bed to chair transfers. The MDS indicated Resident 27 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand).</p> <p>During an observation and interview on 11/6/2024 at 9:15 a.m., in Resident 27's room, Resident 27 was lying in bed. All the fingers of Resident 27's right hand were fully bent at the knuckles with the middle joints and tips of the fingers fully straight. All the fingers of Resident 27's left hand were fully bent at the knuckles with the middle joint of all fingers in a hyperextended position (the extension of a body part beyond it's normal limits). Resident 27 stated staff assisted with putting splints on both of his hands and did not assist with arm ROM exercises.</p> <p>During an observation of an RNA session on 11/7/2024 at 9:48 am, in Resident 27's room, RNA 1 and RNA 2 were standing next to Resident 27 who was seated in a wheelchair next to the bed. RNA 1 applied lotion to Resident 27's both arms, massaged both of Resident 27's hands, and applied splints to Resident 27's both hands. RNA 1 did not provide PROM exercises to Resident 27's both arms. RNA 1 told Resident 27 she would return in four hours to remove both hand splints. RNA 1 and RNA 2 stated the RNA session was complete and only applied splints to Resident 27's both hands because there was no RNA order for ROM exercises for Resident 27's arms.</p> <p>During a concurrent interview and record review on 11/7/2024 at 9:57 a.m., RNA 1 and RNA 2 stated they applied splints to Resident 27's both hands only and did not assist Resident 27 with ROM exercises to both arms because there was no RNA order for ROM exercises. RNA 1 and RNA 2 reviewed Resident 27's RNA orders, dated 9/30/2024, and confirmed Resident 27 had an order for PROM to both arms, three times a week. RNA 1 and RNA 2 stated they did not know Resident 27 had an RNA order for PROM exercises of both arms and thought the RNA order was only for application of both hand splints. RNA 2 stated she should have assisted with PROM to Resident 27's both arms before application of both hand splints but did not. RNA 1 and RNA 2 stated they should have been assisting with PROM to Resident 27's both arms because there was an order but did not because they did not know there was an order. RNA 2 reviewed Resident 27's October 2024 and November 2024 RNA flowsheets. RNA 2 stated an initial in the box indicated RNA treatment was provided that day. RNA 2 confirmed she initialed dates 10/3/2024, 10/8/2024, 10/24/2024, and 10/31/2024 but did not assist with PROM exercises. RNA 1 stated she initialed the boxes to indicate splinting was done and did not notice there was an order for PROM exercises grouped together in the same order. RNA 1 stated the RNA documentation was inaccurate since she did not assist Resident 27 with PROM exercises to both arms.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and record review on 11/8/2024 at 11:40 am, RNA 1 stated she did not return to Resident 27's room later in the day on 11/7/2024 to assist with PROM exercises. RNA 1 reviewed Resident 27's November 2024 RNA flowsheet and confirmed she initialed the box dated 11/7/2024 indicating PROM exercises and application of splints to Resident 27's both arms, wrists, and hands were done that day. RNA 1 stated she initialed the box in reference to the splints being done, not PROM exercises. RNA 1 stated the only way to document that one task was done and not the other was for the RNA to write a note at the end of the week on the RNA weekly summary to indicate the specifics of what was provided and what was not provided since the RNA orders were grouped together. RNA 1 stated she planned to document that only splinting was done on 11/7/2024 at the end of the week since the weekly summary was not yet due, the RNA orders were not separated, and there was nowhere else on the flowsheet to document the details. RNA 1 stated the RNA documentation was inaccurate because the RNA flowsheets indicated PROM exercises were provided to Resident 27's both arms but were not.</p> <p>b. During a review of Resident 31's admission record, the admission record indicated Resident 31 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain) and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right hand.</p> <p>During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had moderately intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and had an impairment on one side of his upper extremities (involving arms or hands).</p> <p>During a record review of Resident 31's history and physical (H&P) form dated 8/6/2024, the H&P indicated Resident 31 had the capacity to understand and make decisions.</p> <p>During concurrent observation and interview in on 11/5/2024 at 11:51 a.m., in Resident 31's room, Resident 31 was wearing a splint on right hand. Resident 31 stated the RNA helps him put on the splint.</p> <p>Resident 31 was also observed wearing a splint on the right hand on 11/6/2024 at 10:00 a.m., 11/7/2024 at 1:20 p.m., and 11/8/2024 at 12:19 p.m.</p> <p>During a concurrent interview and record review on 11/8/2024 at 1:34 p.m., Resident 31's RNA flowsheets were reviewed with RNA 3. RNA 3 stated the RNA's applied Resident 31's splint to the right hand every day. RNA 3 stated there is no documentation to reflect that the RNA's have been applying the splint to Resident 31's hand.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Broadway by the Sea		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. Broadway Long Beach, CA 90803	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 11/8/2024 at 11:50 am, the Director of Nursing (DON) stated the purpose of the RNA program was to ensure the residents in the facility were receiving services to maintain their functional abilities, improve mobility, and prevent contractures. The DON reviewed Resident 27's October 2024 and November 2024 RNA flowsheets and stated an initial in the box indicated Resident 27 was seen for PROM exercises to both arms and application of splints to both hands, wrists, and fingers. The DON stated she did not know how the RNA would accurately document that one task was done and not the other because the RNA orders for PROM and splinting were grouped into one RNA order. The DON reviewed the RNA weekly summaries for October 2024 and November 2024 and stated there was no documentation indicating RNA did not provide PROM exercises to Resident 27's both arms. The DON stated if PROM exercises were not provided, the October 2024 and November 2024 RNA flowsheets were inaccurate since they indicated PROM exercises were provided during all initialed RNA services. The DON stated it was important documentation was accurate to reflect the services being provided, the services not being provided, and if the interventions the facility was providing were effective.</p> <p>During a review of the facility's Policy and Procedure (P/P), titled ROM and Contracture Prevention, dated 2/2023, the P/P indicated it was the facility's policy to ensure residents received services, care, and equipment to assure that every resident maintained and/or improved to his/her highest level of ROM and mobility unless reduction was clinically unavoidable. The P/P indicated appropriate documentation was completed to address goals of the program and resident tolerance to the program.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>45382</p> <p>50387</p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>a. Provide annual documentation verifying the review of their Infection Prevention and Control Program (IPCP) policies and procedures.</p> <p>b. Ensure the Director of Staff Development who was also the interim (temporary) Infection Preventionist Nurse (DSD/IPN), Licensed Vocational Nurse (LVN)¹ and Certified Nurse Assistant (CNA)¹ wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while providing direct contact care to two out of three residents (Resident 1 and 40) who were on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms).</p> <p>These deficient practices had the potential to result in the spread of infections in the facility and cause undue harm to the residents' health and well-being.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 11/7/2024 at 1:42 p.m., with the Director of Staff Development (DSD), who was designated as the backup for the Infection Preventionist (IP), the The Policies and Procedures(P&P) Manual updated January 2024 sign-in sheet, undated, was reviewed. The DSD stated the sign-in sheet did not have a title to indicate which IPCP policies were being reviewed.</p> <p>During an interview on 11/7/2024 at 2:21p.m., with the Assistant Director of Nursing (ADON), the ADON stated that they were not able to provide the proof of IPCP review including title or subject. The ADON stated that the facility needed to update the P&P review sign-in sheet to indicate which P&P's were reviewed.</p> <p>During a concurrent interview and record review on 11/8/2024 at 1:03 p.m., with the Director of Nursing (DON), of the The Policies and Procedures Manual updated January 2024 sign-in sheet, undated, the DON acknowledged that the P&P review sign-in sheet, undated, did not have a title indicating which policies were reviewed. The DON stated, the facility needs to move forward to indicate which subjects or titles were reviewed.</p> <p>During a review of the facility's P&P titled, Infection Prevention and Control Program, revised 12/2023, the P&P indicated that the facility will conduct an annual review of the infection Prevention and Control Program and the program will be updated as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including gastrointestinal hemorrhage (any type of bleeding that occurs in the digestive track) and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 1's Order Summary Report, the Order Summary Report indicated a physician's order for Resident 1 to be placed on EBP due to the presence of an indwelling medical device/feeding tube (tube placed directly into the stomach for long-term feeding).</p> <p>During an observation on 11/06/2024 at 10:02 a.m., the DSD/IPN entered Resident 1's room, donned (put on) gloves, and walked over to Resident 1's bed. The IPN was not wearing an isolation gown. The IPN removed Resident 1's blankets, lifted Resident 1's left arm, replaced Resident 1's blanket, grabbed Resident 1's neck pillow from the bedside dresser, lifted Resident 1's head, placed the neck pillow around Resident 1's neck, and helped reposition Resident 1 for comfort.</p> <p>During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of greater trochanter of right femur (hard area on the outside of the hip), subsequent encounter for closed fracture (bone breaks but the skin remains intact) with routine healing, age related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with pathological fracture (broken bone caused by disease), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 40's Minimum Data Set ([MDS]), a federally mandated screening tool, dated 7/12/2024, the MDS indicated Resident 40's cognitive skills (ability to think and reason) for daily decision-making were moderately impaired.</p> <p>During a review of Resident 40's Order Summary as of 11/7/2024, the summary indicated:</p> <p>a. Starting 10/9/2024, enhanced barrier precautions: personal protective equipment, (PPE - gear worn to protect wearer from hazards) required for high resident contact care activities. Indication alteration in skin integrity.</p> <p>b. Starting 10/12/2024, Medi honey Wound/burn dressing external gel (a medical-grade wound care product line that uses honey to treat wounds and burns) apply to sacro-coccyx (tail bone) topically as needed for stage 3 pressure injury (Full-thickness loss of skin, Dead and black tissue may be visible) may replace dressing if dislodges.</p> <p>c. Starting 11/6/2024, Medi honey Wound/burn dressing external gel to sacro-coccyx topically every dayshift for stage 3 pressure injury. Cleanse with normal saline (solution of water and salt), pat dry, apply Medi honey, apply skin prep to peri wound then cover with dry dressing.</p> <p>During an observation on 11/7/2024 at 1:26 p.m., in Resident 40's room, LVN 1 and was observed administering wound care treatment to Resident 40 without wearing an isolation gown. CNA 1 was assisting LVN 1 also without an isolation gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/6/2024 at 10:13 a.m., the DSD/IPN stated she did not wear an isolation gown while providing direct contact care to Resident 1 who was on EBP precautions. The IPN confirmed Resident 1 was on EBP precautions and stated she should have worn an isolation gown because she provided direct contact care which involved touching Resident 1's body. The IPN stated all staff providing direct patient care to residents on ESP precautions must wear the appropriate PPE which included an isolation gown and gloves to prevent the spread of infection. The IPN stated it was important to follow infection control protocols to protect the residents and staff from infection and cross contamination.</p> <p>During an interview on 11/7/2024 at 1:58 p.m., with LVN 1, LVN 1 stated she forgot to don an isolation gown and stated from now on she will wear an isolation gown.</p> <p>During an interview on 11/8/2024 at 11:50 a.m., with the Director of Nursing (DON), the DON stated it was important that staff followed the proper infection control protocols to prevent the spread of infection.</p> <p>During a review of the facility's P&P titled, Infection Prevention and Control Program Standard and Transmission based precautions, revised 3/2024, the P&P indicated, the use of isolation gown and gloves for high-contact activities is indicated for residents with wounds and or indwelling device.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's rooms had 80 square feet per resident in multiple resident rooms.</p> <p>This deficient practice had a potential for affecting the residents' quality of life, safety, health, and provision of care.</p> <p>Findings:</p> <p>During record review of the facility's client accommodation analysis form the following resident rooms measured as follows:</p> <p>room [ROOM NUMBER], 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 21, 24, 25, 27, 29, and 39 accommodated three residents per room and they measured 223 square feet.</p> <p>room [ROOM NUMBER], 18, 20, 22, 28, 30, 31, 32, 33, 34, 35, 36, and 37 accommodated two residents per room and they measured 144 square feet.</p> <p>During an interview with the Administrator (ADMIN) on 11/8/24 at 8:30 a.m., ADMIN stated, he requested for a room waiver for at least 80 square feet per resident for 36 rooms and it will not adversely affect the residents health or safety.</p> <p>During observation from 11/4/2023 thru 11/8/2024 there were no issue observed with resident's needs, health, and safety were not affected by room size. The Department is recommending continuation with the room waiver.</p>		