

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a microscope) that could cause foodborne illness (food poisoning) for 74 out of 84 total residents in the facility by failing to:1. Ensure a bag of mixed vegetables in the refrigerator were properly stored and labeled with an open date.2. Ensure a box of waffles were stored and sealed properly in the freezer.3. Ensure a bag of sweet potato fries were stored properly in the freezer labeled with an open date. These deficient practices had the potential to result in pathogen (germ) exposure and placed residents at risk for developing foodborne illnesses with symptoms including nausea, vomiting and diarrhea. Findings:During a concurrent observation and interview on 1/5/2026 at 8:28 a.m., the initial kitchen tour was conducted with the Dietary Supervisor (DS). There were observations of the facility refrigerator that contained a bag of mixed vegetables in the refrigerator that was not properly stored and did not have a label with an open date. There was an observation in the freezer of a bag of sweet potato fries and a box of waffles that were not stored properly, and the sweet potato fries did not have an open date. The DS stated his cook (CK 1) used the mixed vegetables for an omelet (unknown date) and forgot to label and date the leftovers. The DS stated they serve a vulnerable population, and they could be negatively affected by unsafe food handling. During an interview on 1/5/2026 at 11:06 a.m., with the Registered Dietician (RD), the RD stated all food stored in the kitchen needed to have a delivery date, date opened, and/ or a use by date (the last day recommended for consuming a food product while it's still at its best quality) so that spoiled food or food of poor quality was not served to the residents. The RD stated all food items needed to be properly sealed and covered so the food was not open to air because oxidation (a chemical reaction that occurs when food is exposed to oxygen, causing it to break down and lose its nutritional value) occurs and the food spoils faster. The RD stated it was the dietary staff responsibility to ensure food was labeled, dated, and stored properly. During a review of the facility's policy and procedure (P&P) titled Food Receiving, labeling, and Storage dated 11/2022, the P&P indicated all foods stored in the refrigerator or freezer were to be covered, labeled, and dated (use by date).		

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' medical records were up to date as per the facility's policy and procedure (P&P) regarding advance directives ([AD], a legal document of a resident's wishes regarding medical treatment) for four of five sampled residents (Resident 2, Resident 8, Resident 11, and Resident 86). These deficient practices violated the residents' rights to be fully informed of the option to formulate an AD and had the potential to cause conflict with the residents' wishes regarding health care in the event residents became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff. Findings: A. During a review of Resident 2's admission record, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] and last re-admission was on 11/4/2025 with diagnoses including sepsis (a life-threatening blood infection), End Stage Renal Disease (ESRD-irreversible kidney failure), and dependence on dialysis (mechanical removal of toxins from the blood due to the body's inability to do so). During a review of Resident 2's History and Physical (H&P), dated 11/4/2025, the H&P indicated, Resident 2 had the capacity (ability) to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 2 required maximal assistance (Helper does more than half the effort) from one staff for shower/bath, transfer, toilet hygiene, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, dressing, and setup or clean up assistance (Helper sets up or cleans up) from one staff for eating, and oral hygiene. During a concurrent interview and record review on 1/7/2026, 10:14 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 2's Physician Orders for Life-Sustaining Treatment ([POLST]- a set of medical orders that communicate a patient's wishes for end-of-life interventions), dated 11/4/2025 was reviewed. The POLST section D (Information and Signature) indicated, the Advance Directive (AD- a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) availability and discussed AD with the resident or legal decision maker sections were left blank. RNS 1 stated, all sections of the POLST should be completed including section D regarding AD. RNS 1 stated, it was important to complete the AD section to honor the resident's wishes because the resident would be treated as Full Code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive including invasive procedures) against his/her wishes if it was not completed. During a concurrent interview and record review on 1/7/2026, at 3:02 p.m., with the Social Service Director (SSD), Resident 2's Social Services Assessment (SSA), dated 11/17/2025 was reviewed. The SSA indicated, the SSD verbally educated Resident 2 about the right to formulate an AD, Resident 2 was not interested at this time. The SSD stated, she did not have any written evidence that she provided the written education regarding the right to formulate an AD. The SSD stated, she thought she provided verbal education, but she should have provided written information as well. The SSD stated, it was her responsibility to ensure documenting the availability of an AD and the discussion (with Resident 2) regarding an AD with Resident 2 or their decision maker on POLST to honor the (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's wishes regarding care and treatment. B. During a review of Resident 8's admission record, the admission record indicated Resident 8 was admitted to the facility on [DATE] with osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right ankle and foot, unstageable pressure ulcer (a full-thickness wound where the base is hidden by dead tissue, making its true depth and severity impossible to determine until the covering is removed) on sacral area (the triangular bone [sacrum] at the base of the spine, located between the lower back [lumbar vertebrae] and the tailbone [coccyx], connecting the spine to the pelvis), and surgical removal of fingers and left toes. During a review of Resident 8's History and Physical (H&P), dated 8/1/2025, the H&P indicated, Resident 8 had the capacity (ability) to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, dressing, toileting hygiene, transfer, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating. During a concurrent interview and record review on 1/7/2026, at 10:35 a.m., with RNS 1, Resident 8's POLST, dated 8/1/2025 was reviewed. The POLST section D (Information and Signature) indicated, no AD and there was no documentation regarding discussion with Resident 8 or Resident 8's decision maker for AD. RNS 1 stated, she could not tell if the right to formulate an AD was discussed with Resident 8 based on POLST because it was not documented. During a concurrent interview and record review on 1/7/2026, at 3:18 p.m., with the SSD, Resident 8's Social Service Summary (SSS), dated on 11/11/2025 was reviewed. The SSS indicated, the SSD verbally educated Resident 8 on the right to formulate an AD, but Resident 8 was not interested. The SSD stated, she could not provide any evidence that she provided education to Resident 8 on the right to formulate an AD. The SSD stated, she should have made sure that written information was given to Resident 8. The SSD stated, she should have ensured that POLST section D regarding the discussion with the resident or decision maker was documented. During an interview on 1/8/2026, 3:22 p.m., with the Director of Nursing (DON), the DON stated, AD and POLST should be available for all residents regardless. The DON stated, SSD and staff should have ensured the completion of POLST and provided written information regarding AD. The DON stated, AD and POLST were important to honor residents' wishes and the guideline for how to treat residents in emergency situation. C. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dysphagia (difficulty swallowing), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was rarely or never understood, and required supervision (helper provides verbal cues and/or touch assistance) with self-care abilities such as personal and oral hygiene, dressing and was maximal assistance (helper does more than half the effort) with mobility such as sit to stand and transfers. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's H&P dated 3/10/2025, the H&P indicated Resident 11 was not alert and oriented to person, place, or time. The H&P indicated Resident 11 was forgetful, an inaccurate historian and unable to make medical decisions. During a review of Social Services assessment dated [DATE], the Social Services Assessment indicated Resident 11 and/or Resident 11's representatives had been informed in a manner easily understood of their right to formulate advanced directives. The Social Services Assessment indicated Resident 11 was not a good candidate for formulating an advance directive. The Social Services Assessment did not indicate if Resident 11's representatives had been informed of the right to formulate an advance directive. D. During a review of Resident 86 's admission Record, the admission Record indicated Resident 86 was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), benign neoplasm of parotid gland (a noncancerous growth, appearing as a slow-growing, painless lump in front of the ear), and diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had severe cognitive (thought process) impairment for daily decision making, and was maximal assistant with self-care abilities such as toileting hygiene, bathing, and personal hygiene and was moderate assistance with mobility such as sit to stand and transfers. During a review of Resident 86's Social Services Assessment, dated 11/17/2025, the Social Services Assessment indicated Resident 86 and/or Resident 86's representatives had been informed in a manner easily understood of their right to formulate advance directives. The Social Services Assessment indicated Resident 86 was alert and oriented times two (a person is aware of their person (knows their name) and their place (knows where they are), but may not know the time (date/day/season) or situation (why they are there). The Social Services Assessment indicated Resident 86 had a family member involved in care. The Social Services Assessment indicated Resident 86 had periods of confusion; and Resident 86 was not a good candidate to formulate an advance directive at this time. There was no indication on the Social Services Assessment whether Resident 86's representatives had been informed of the right to formulate an advance directive. During a concurrent interview and record review on 1/7/2026 at 3:01 p.m., with the SSD, Resident 11 and Resident 86's Social Service Assessments dated 11/17/2025 were reviewed. The SSD stated Resident 11 did not have an AD. The SSD stated Resident 11 was confused during admission and was not able to formulate an AD. The SSD stated Resident 11 was not a good candidate for formulating an AD. The SSD stated the assessment was not clear whether Resident 11's representative was informed of the right to formulate an AD. The SSD stated for Resident 86, the resident could not formulate an AD. The SSD stated Resident 86 could make decisions, but was not able to formulate an AD due to being confused at times. The SSD stated the Social Service Assessment was not clear whether Resident 86's representative was informed of the right to formulate an AD. During an interview on 1/8/26 at 3:30 p.m. with the Director of Nursing (DON), the DON stated an AD was a document of the residents' wishes, and the care they would want if they become incapacitated. The DON stated if residents were not provided education to formulate AD, the residents and/or resident representatives are not able to able to formulate an AD on what the wishes are for the residents and their care in the facility. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled Advance Directive and Associated Documentation, revised in 04/2025, indicated it is the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. The facility recognizes and respects the residents' right to choose their treatment and make decisions about care to be received at the end of their life .1. prior to, upon, or immediately after admission, a facility staff member shall: a. provide the resident/family or responsible agent written information, in a manner easily understood by the resident or resident representative, regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. b. document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives. c. inquire whether they have completed an Advance Directive. 2. If the resident is incapacitated at the time of admission and is unable to receive information or indicate whether they have executed an advance directive, the facility may give advance directive information to the resident's representative in accordance with existing State law.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide accurate information in the Minimum Data Set ([MDS], a resident assessment tool) for three of four sampled residents (Resident 11, Resident 33, and Resident 86). The facility failed to indicate: Resident 11 had a gastrostomy/feeding tube ([G-Tube], a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). Resident 33 was receiving Restorative Nursing Assistant services ([RNA] services helps residents regain and maintain physical function, mobility, and independence through specialized exercises, transfers, and positioning). Resident 86 was receiving RNA services. This deficient practice had the potential to result in inaccurate assessment and services for the residents due to inaccurate MDS assessments and care screening tool practices. Findings: a. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dysphagia (difficulty swallowing), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 11's Order Summary Report dated 10/18/2025, the Order Summary Report indicated enteral (nutrition administered through the stomach or intestines) feed order two times a day Glucerna 1.5 (a calorically dense formula to help minimize blood sugar) at 66 mL/hr (milliliter per hour, a unit of measurement of flow rate used primarily in healthcare for fluid administration) to provide 480 mL/720 kcal (kilocalories, the same unit of energy, measures the energy your body gets from food and uses for activities to provide energy) two times a day, turn on at 8:00 p.m. and off at 4:00 a.m. or until complete. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was rarely or never understood and the brief interview for mental status was not done for daily decision making, and required supervision (helper provides verbal cues and/or touch assistance) with self-care abilities such as personal and oral hygiene, dressing and was maximal assistance (helper does more than half the effort) with mobility such as sit to stand and transfers. The MDS indicated Resident 11 did not have a feeding tube such as a nasogastric (a soft, flexible tube inserted through the nose, down the esophagus, and into the stomach for short-term medical purposes, such as delivering nutrition) or abdominal tube (G-Tube) for nutritional approaches while a resident in the facility. b. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses of spinal stenosis (the narrowing of spaces within your spine, putting pressure on the spinal cord and nerves, often causing pain, numbness, cramping, or weakness in the back, legs, or arms), chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, affecting the arm, leg, or face). During a review of Resident 33's Order Summary Report dated 10/10/2025, the Order Summary Report indicated RNA program for both lower extremities (legs) [active assisted range of motion ([AAROM] a technique where an individual use their own muscles to move a limb with help from a therapist to improve strength and flexibility) using a cycle (a bike that assists individuals who struggle to participate in therapeutic exercise due to strength, coordination or neurological challenges) every day two times a week or as tolerated. During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 33 had intact cognitive (thought process) skills for daily decision making, and was maximal assistant with self-care abilities such as oral hygiene, bathing, and putting on shoes and was moderate assistance (helper does less than half the effort) with mobility such as sit to stand and transfers. The MDS indicated Resident 33 did not participate in RNA program. c. During a review During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	benign neoplasm of parotid gland (a noncancerous growth, appearing as a slow-growing, painless lump in front of the ear), and diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 86's Order Summary Report dated 10/18/2025, the Order Summary Report indicated RNA program AAROM of bilateral upper extremities ([BUE's], both arms) and BLEs with a cycle three times a week or as tolerated.During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had severe cognitive impairment for daily decision making, and was maximal assistant with self-care abilities such as toileting hygiene, bathing, and personal hygiene and was moderate assistance with mobility such as sit to stand and transfers. The MDS indicated Resident 86 did not participate in RNA program.During a concurrent interview and record review on 1/7/2026 at 3:53 p.m. with the MDS Coordinator (MDSC), the Order Summary Reports, and MDS dated [DATE], 11/28/2025, and 12/5/2025 were reviewed. The MDSC stated for Resident 33 and Resident 86, they would look at orders, and if the orders were still active, then look at RNA progress notes to see if the residents were still getting RNA services. The MDSC stated the Resident 33 and Resident 86 were getting RNA services. The MDSC stated if it was not documented that residents received the 15 minutes session, then the RNA services were not done. The MDSC stated if residents do not get RNA services, the residents can decline functionally (lose ability to do activities of daily living). The importance of residents receiving RNA services as ordered was to maintain their function and to not decline in their ROM, and ambulation. The MDSC stated for Resident 11, the MDS assessment was miscoded. The MDSC stated all MDS coding should be accurate, for their plan of care, what the residents have and the care the facility was providing to the residents.During an interview on 1/8/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the MDS assessment was an assessment of the resident, what the resident has and what type of care was being provided to residents before transmitted to Centers for Medicare and Medicaid Services ([CMS], provides health coverage through Medicare, Medicaid, and the Children's Health Insurance Program). The DON stated the importance of accurate MDS coding was the overall accuracy of what the resident has, the status of the resident and to get credit for the care the facility was providing to the resident and if it was miscoded, the facility was not treating the residents according to what they have.During a review of the facility's policy and procedure (P/P), titled Resident Assessment and Associated Processes, revised 4/2025, indicated it is the policy of this facility that residents will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessments of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment, as well as the date the data was obtained.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of three sampled residents (Resident 71 and Resident 49) related to: A. Failing to monitor and document Resident 71's intake and output for suprapubic catheter (a thin tube inserted through a small opening in the lower abdomen directly into the bladder to drain urine) daily accurately.B. Failed to monitor and document Resident 49's intake and output for urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) every shift and every 24 hours. This failure had the potential to result in Resident 71 and 49's needs not being met, affecting the residents' well-being, including significant changes in urine output being missed, and poor patient outcomes.Findings: A. During a review of Resident 71's admission record, the admission record indicated Resident 71 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with sepsis (a life-threatening blood infection), acute (sudden onset) pyelonephritis (a sudden, serious bacterial infection and inflammation of the kidney), and chronic kidney disease (the kidneys have become damaged over time). During a review of Resident 71's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 71 had fluctuating (irregularly varied) capacity to understand and make decisions. During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 71 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, dressing, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, toilet hygiene, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating and oral hygiene. During a concurrent interview and record review on [DATE], at 10:14 a.m., with Registered Nurse Supervisor (RNS)1, Resident 71's Order Summary Report (OSR), dated [DATE] was reviewed. The OSR indicated, Resident 71 had a suprapubic catheter to closed drainage system (a sterile medical system that collects fluids from a surgical site or wound through a drainage tube) for obstructive uropathy (a urinary tract disorder due to structural or functional obstruction of urinary flow) ordered on [DATE]. The OSR indicated, calculate total 24 hours intake and output on every night shift, ordered on [DATE]. RNS 1 stated, Resident 71 was transferred to a General Acute Care Hospital (GACH) due to leakage of the suprapubic catheter on [DATE]. RNS 1 stated, Resident 71's Primary Care Physician (PCP) emphasized the importance of monitoring and documenting intake and output accurately to prevent complications such as blockage and leakage for the suprapubic catheter. During a concurrent interview and record review on [DATE], at 10:20 a.m., with RNS 1, Resident 71's Medication Administration Record (MAR), dated from 10/2025 to [DATE] was reviewed. The MAR indicated, calculate total 24 hours intake and output on every night shift as follows: a. there was no documentation regarding intake and output amount in milliliter (ml) on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. b. total output was documented as frequency instead of measurement on [DATE] (twice: x2), (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] (x2), [DATE] (x2), [DATE] (x2), [DATE] (x2), [DATE] (once: x1), [DATE] (x2), [DATE] (x2), [DATE] (x2), and [DATE] (x1). c. total output was documented total output as zero ml or N/A (not applicable) on [DATE] (0ml) and [DATE] (N/A). RNS 1 stated, Resident 71's intake and output were not monitored and documented accurately. RNS 1 stated, output from the suprapubic catheter should be documented in measurable units ml instead of documenting the frequency such as once or twice. RNS 1 stated, if the total 24 hour output was zero, that would indicate something was wrong and it should be documented as a Change in Condition (CIC) Evaluation (a significant alteration in an individual's physical status) and the PCP should be notified. RNS 1 stated, there was no CIC Evaluation that was done on [DATE]. During a concurrent interview and record review on [DATE], at 3:33 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 71's Care Plan Report (CPR), revised [DATE] was reviewed. The CPR Focus indicated, Resident 71 had a suprapubic catheter. The CPR Goal indicated Resident 71 would remain free from catheter related trauma through [DATE]. The CPR Interventions included, calculate total 24 hours intake and output on every night shift. The MDSC stated, all care plan interventions should be implemented to provide proper care. The MDSC stated, inaccurate monitoring and documenting of intake and output would lead to inaccurate resident assessment. The MDSC stated, this would delay the treatment and care of complications such as blockage and leakage of suprapubic catheter. During an interview on [DATE], 3:08 p.m., with the Director of Nursing (DON), the DON stated, the resident's care plan is that specific resident's plan of care, and it should be implemented as it stated. The DON stated, care plan interventions should be implemented and reevaluated. The DON stated care plan interventions were from IDT meeting and should be implemented to prevent recurrent events or problems. B. During a review of Resident 49's admission Record, the admission Record indicated Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including benign prostatic hyperplasia ([BPH], a common, non-cancerous growth of the prostate gland that squeezes the urethra, causing urinary issues like weak stream, and incomplete bladder emptying), urinary tract infection ([UTI]- an infection in the bladder/urinary tract), and dementia (a progressive state of decline in mental abilities). During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 had intact cognitive (thought process) functioning for daily decision making and was moderate assistance (helper does less than half the effort) with self-care abilities such as eating, oral hygiene, personal hygiene and upper body dressing and required supervision (helper provides verbal cues as resident completes activity) for sit to stand and transfers. During a review of Resident 49's Order Summary Report, the Order Summary Report indicated to calculate total 24 hours intake and output on PM shift, every night shift ordered on [DATE] and to monitor intake and output every shift for use of foley catheter ordered on [DATE]. During a review of Resident 49's untitled care plan, revised on [DATE], the untitled care plan focus indicated resident had an indwelling catheter for BPH obstructive uropathy (any blockage in the urinary tract that causes urine to back up) at risk for infections and related complications with goals (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of will show no signs or symptoms of urinary infection through review date and interventions to calculate total 24 hours intake and output on the PM shift every night. The untitled care plan dated [DATE] indicated a focus of at risk for UTI due to sediment and foul odor urine noted in foley catheter with goals of will have no signs or symptoms of complications until next review date and interventions to monitor intake and output. During a review of Resident 49's MAR for [DATE], [DATE] and [DATE], the MAR indicated calculate total 24 hours intake and output on PM shift every night shift, there was missing documentation on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The MAR indicated monitor intake and output every shift for use of foley catheter, there was missing documentation on [DATE] nocturnal shift (a work schedule that covers overnight hours, typically from 11 p.m. to 7 a.m.), [DATE] p.m. shift (a work schedule that occurs starting around 3 p.m. and ending around 11 p.m.), [DATE] nocturnal shift, [DATE] nocturnal shift, [DATE] nocturnal shift, [DATE] nocturnal shift, [DATE] nocturnal shift, [DATE] day shift (typically covers the standard working hours from 7 a.m. to 3 p.m.), [DATE] day shift, [DATE] p.m. shift, [DATE] nocturnal shift, and [DATE] nocturnal shift. During a concurrent observation and interview on [DATE] at 10:43 a.m., with Resident 49 in his room, Resident 49 was lying in bed watching television. Resident 49 stated he had a urinary catheter inserted because he could not urinate like before. Resident 49 stated he was having trouble urinating and kept getting UTIs. During a concurrent interview and record review on [DATE] at 4:06 p.m., with the MDSC, the untitled care plan dated [DATE], and the MAR for [DATE], [DATE] and [DATE] were reviewed. The MDSC stated the importance of monitoring resident's intake and output was to make sure the resident's kidney function was functioning properly. The MDSC stated if the resident has a condition where their kidney function was affected, it was important to accurately document the intake and output to make sure the resident was not in fluid overload, and the kidneys were functioning properly. The MDSC stated that for the missing documentation of output from the foley catheter, indicated the monitoring was not done. During an interview on [DATE] at 3:30 p.m., with the Director of Nursing (DON), the DON stated a care plan was a plan of care for residents that included interventions that staff should implement. The DON stated care plans are person centered and if the care plan indicated to document intake and output, the interventions must be followed. The DON stated if the intake and output are not accurately documented, the resident could be retaining urine the staff does not know about, and the kidney function could be compromised. During a review of the facility's policy and procedures (P&P) titled Comprehensive Person Centered Care Planning revised [DATE], indicated, it is the policy of this facility that the interdisciplinary team ([IDT], a collaborative group of various professionals such as nurses, doctors, therapists, social workers, dietitians, etc. working together with the patient and family to create a comprehensive, person-centered care plan) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plans for two out of twelve sampled residents (Resident 5 and Resident 6) were revised to reflect their current plan of care by failing to ensure: a. The care plan for Resident 5 was updated to reflect his current nutritional needs b. The care plan for Resident 6 was updated to reflect his current urinary continence status This deficient practice had the potential for Resident 5 and Resident 6 to not receive person centered care. Findings: a. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses of dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells) and encephalopathy (a broad term for any widespread brain disease or dysfunction, altering brain function due to infections injury). During a review of Resident 5's Care Plan Report titled, Resident requires tube feeding the Care Plan Report indicated Resident 5 had an active care plan that was initiated on 8/21/2025 for tube feeding related to history of dysphagia (problems swallowing) and weight loss. The interventions for Resident 5 included receiving Glucerna (a type of nutritional formula) 1.5 via gastrostomy tube (a tube inserted directly into the stomach for nutrition) at 75 milliliters (ml, a unit of measurement) an hour for 20 hours a day to provide 1550 ml of formula and 2250 kilocalories (kcal, a unit of measurement of energy). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 10/8/2025, the MDS indicated Resident 5 had severe cognitive impairment (a significant loss in memory, thinking, and decision-making abilities, making independent living difficult or impossible). During an interview on 1/7/2025 at 9:26 a.m., licensed vocational nurse (LVN) 1 stated Resident 5's diet was upgraded, and he no longer received nutrition via the gastrostomy tube, he ate by mouth. During an interview and concurrent record review on 1/8/2025 at 1:18 p.m., with the Director of Nursing (DON), Resident 5's current physician's orders were reviewed. The DON stated she reviewed Resident 5's current physician's orders and Resident 5 had been eating by mouth since 11/20/2025 and no longer had a physician's order for tube feeding (stop date 12/5/2025). The DON stated it was important to have accurate care plans that have been revised to reflect residents 5's status so the healthcare team could be on the same page. The DON stated Resident 5's current care plan reflected Resident 5 was continuing to receive tube feeding for nutrition and that was not correct. The DON stated Resident 5's care plan should have been revised and care plans are revised when there are any changes to the plan of care. During a review of the facility's policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning dated 4/2025, the P&P indicated the resident's comprehensive plan of care would be reviewed and/or revised after both comprehensive and quarterly reviews. b. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects brain function), chronic kidney disease, and benign prostatic hyperplasia (BPH - (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an enlargement of the prostate gland causing difficult urination and incomplete bladder emptying). During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6's cognition (ability to learn, reason, remember, understand, and make decisions) was intact, required supervision when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, required maximal assistance (helper does more than half the effort) for toileting hygiene and bathing, and was dependent for lower body dressing. During a concurrent observation and interview on 1/5/2026 at 10:58 a.m., with Resident 6, Resident 6 stated he used to have a urinary catheter (a flexible tube that drains urine from your bladder into a bag outside the body), but now uses a urinal when urinating. No catheter bag was observed with Resident 6. During a concurrent interview and record review on 1/7/2026 at 11:25 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 6's medical record was reviewed. RNS 1 stated Resident 6's urinary catheter was discontinued on 11/20/2025. RNS 1 stated Resident 6's care plan for titled, Has risk for urinary retention related to BPH, initiated on 12/1/2025 indicated interventions to educate family and/or resident on catheter care and importance of catheter care, provide catheter care if urinary catheter is present, and urinary catheterization as indicated and maintain patency (no blockage) of catheter. RNS 1 stated the care plan is incorrect and should have been revised when the urinary catheter was removed. During an interview on 1/8/2026 at 2:01 p.m., the DON, the DON stated it was important to revise care plans so there is a continuity of care and to ensure that we are giving the right care to the resident. The DON stated care plans should be revised when there is a change of condition, changes with care or medication, and quarterly. During a review of the facility's policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning dated 4/2025, the P&P indicated the resident's comprehensive plan of care would be reviewed and/or revised after both comprehensive and quarterly reviews.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of three sampled residents (Resident 3 and Resident 2) who received hemodialysis (HD-process of removing waste products and excess fluid from the body) treatment received care in accordance with standards of practice, as evidenced by: A. Failing to ensure Resident 2 received Hemodialysis twice a week as ordered B. Failing to ensure resident 3 who received hemodialysis had an emergency kit at resident's bedside. These failures had the potential to result in Resident 2 suffering from complications such as fluid overload (too much fluid builds up in the body, causing swelling), electrolyte imbalance (the body has too much or too little of essential minerals), and dangerous buildup of toxins/waste and Resident 3 receiving delayed intervention during accidental bleeding. Findings: During a review of Resident 2's admission record, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] and last re-admission was on 11/4/2025 with sepsis (a life-threatening blood infection), End Stage Renal Disease (ESRD-irreversible kidney failure), and dependence on dialysis. During a review of Resident 2's History and Physical (H&P), dated 11/4/2025, the H&P indicated, Resident 2 had the capacity (ability) to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 2 required maximal assistance (Helper does more than half the effort) from one staff for shower/bath, transfer, toilet hygiene, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, dressing, and setup or clean up assistance (Helper sets up or cleans up) from one staff for eating, oral hygiene. During an interview on 1/5/2026, at 11:28 a.m., with Resident 2 in his room, Resident 2 stated, he was scheduled to go to Hemodialysis (HD) twice a week (Monday and Friday). Resident 2 stated, he missed his HD appointment on 1/2/2026 (Friday) because no one came to pick him up for HD appointment. Resident 2 stated, he was concerned that he might miss another appointment and suffering from complications such as confusion and heart issues due to toxin accumulation. Resident 2 stated, no one arranged the makeup session for his missed HD session. During a concurrent interview and record review on 1/7/2026, at 10:14 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 2's Order Summary Report (OSR), dated 1/7/2026 was reviewed. The OSR indicated, Hemodialysis on Monday and Friday with pick up time at 1:15 p.m. was ordered 11/4/2025. RNS 1 stated, Resident 3 had an order to receive HD twice a week. RNS 1 stated, she was not sure the reason why Resident 3 missed HD on 1/2/2026 and there was no documentation. RNS 1 stated, Resident 3 should have received his makeup HD session, but there was no makeup HD session scheduled. RNS 1 stated, the staff should have notified the doctor for further recommendation if the resident missed HD to prevent the complications. During a concurrent interview and record review on 1/7/2026, at 10:18 a.m., with RNS 1, Resident 2's Dialysis Care Documentation/Communication (DCDC) Log, dated from 12/29/2025 to 1/5/2026 was reviewed. The DCDC Log indicated, there was no documentation on 1/2/2026. RNS 1 stated, DCDC documented before and after HD session. RNS 1 stated, resident's weight, vital signs (measurements (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the body's essential functions, typically including body temperature, pulse rate, respiratory rate, and blood pressure), HD access site assessment, assessment of potential complications, location of HD received, any new order from HD center were documented on DCDC. RNS 1 stated, there was no documentation between 12/29/2025 and 1/5/2026. RNS 1 stated, Resident 2 did not receive HD on 1/2/2026 and no makeup session scheduled. During an interview on 1/7/2026, at 11:50 a.m., with the Case Manager (CM), the CM stated, she thought that Resident 2 refused to go HD on 1/2/2026, but there was no documentation regarding this. The CM stated, nursing staff should have documented and notified the doctor for recommendation. The CM stated, she did not hear anything from the nursing staff and she did not arrange makeup HD session. During an interview on 1/7/2026, 3:02 p.m., with the Social Service Director (SSD), the SSD stated, she was not notified regarding Resident 2's missing HD session. The SSD stated, if the HD appointment was missing, the staff should have followed up and notified her, the CM and she could arrange the makeup HD session. The SSD stated, HD was important to prevent complications such as irregular heart rhythm due to high potassium (too much potassium in the blood, causing symptoms from fatigue to dangerous heart problems, and is managed with diet, meds, or dialysis) and fluid overload. During an interview on 1/8/2026, at 3:22 p.m., with the Director of Nursing (DON), the DON stated, missing HD session could cause serious health problems such as shortness of breath (the feeling of not getting enough air, often described as chest tightness, struggling to breathe, or feeling like you're suffocating), confusion, and arrhythmia (irregular heartbeats). The DON stated, the staff should have followed through with HD appointments and notified the doctor when the resident missed HD session. During a review of the facility's Policy and Procedure (P&P) titled, Dialysis, Transportation Arrangements for, revised 4/2025, the P&P indicated, Policy: It is the policy of this facility to assist residents in arranging transportation to and from an off-site dialysis facility. Procedure: 1. If a resident requires dialysis appointments as part of his/her care and treatment plan at an off-site certified dialysis facility, the facility should coordinate with resident or resident representative in establishing transportation arrangements . 3. Requests for transportation should be made as far in advance as possible. During a review of the facility's Policy and Procedure (P&P) titled, Transportation to Diagnostic/Dialysis Appointment, revised 5/2019, the P&P indicated, Policy: It is the policy of this facility to assist residents in arranging transportation to/from diagnostic/dialysis appointments when necessary. Procedure: 3. Should it become necessary for the facility to provide transportation, the social service designee will be responsible for arranging the transportation. During a review of the facility's Policy and Procedure (P&P) titled, Dialysis (Renal), Pre-and Post-Care, revised 4/2025, the P&P indicated, Policy: It is the policy of this facility to participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Collaboration and Communication of Care: 1. The care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff. 2. Staff will immediately contact and communicate with the attending physician/practitioner, resident/resident representative, and designated dialysis staff regarding any significant changes in the resident's status. Documentation: 1. Documentation related to pre- and post-dialysis care will be placed in the clinical record and include .c. Communication between facility (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and dialysis staff or medical provider. During a review of the facility's Policy and Procedure (P&P) titled, Ancillary Services, revised 12/2023, the P&P indicated, Policy: It is the policy of this facility that Social Services staff will coordinate ancillary services to promote residents' optimal well-being. Procedures: 1. Social Services will maintain a system to monitor ancillary services. During a review of Resident 3's admission Record (Face sheet), the admission Record indicated the facility admitted Resident 3 on September 7, 2025 with diagnoses that included end stage renal disease (ESRD, when kidneys are no longer able to work as they should to meet the needs of the body) dependence on hemodialysis (a treatment that cleans a person's blood when kidney is not working), type 2 diabetes mellitus (adult onset diabetes - a chronic condition that affects the way the body processes blood sugar), During a review of the Physician's Orders, dated 11/1/2025, Resident 3 required hemodialysis every Tuesday, Thursday and Saturday at 8:20 a.m. During a review of the Minimum Data Set (MDS - assessment and care-screening tool), dated 9/23/2025, the MDS indicated Resident 3's cognition was intact, was independent in making decisions regarding daily tasks. The MDS indicated Resident 3, required extensive assistance on staff for transfer, dressing, toilet use, personal hygiene, and bathing. During an interview on 1/7/2026 at 10:21 a.m., with Resident 3, the resident stated he had not seen an emergency dialysis kit (supplies to manage sudden bleeding from the dialysis access site) in his bedside drawer. During an observation and interview on 1/7/2026 at 11:07 a.m., with Licensed Vocational Nurse (LVN) 8, LVN 8 looked in Resident 3's bedside table, drawers and closet and stated she could not find an emergency kit to use in case of emergency bleeding for Resident 3. During an observation and interview on 1/7/2026 at 11:21 a.m., with Assistant Director of Nurses (ADON), the ADON stated they did not know where Resident 3's emergency kit was. During an interview and record review on 1/8/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated Resident 3, should have an emergency kit at resident's bedside. During a review of the facility's policy and procedure (P&P) titled Dialysis Pre-Post Care dated 4/2025, the P&P indicated, any problems with resident's access site such as excessive bleeding should be addressed immediately.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to educate and offer the COVID-19 (a highly contagious infection) vaccination (medication to reduce risk for infection) for the 2025-2026 respiratory infection season (October 2025 - March 2026) for one of five sampled residents (Resident 7) and all staff. These failures had the potential to result in spreading the COVID-19 virus. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute exacerbation and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 7 had severed cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, oral hygiene, and lower body dressing , and required supervision for toileting hygiene, personal hygiene, bathing, and lower body dressing. The MDS indicated Resident 7's COVID-19 vaccination is not up to date. During a concurrent interview and record review on 1/8/2026 at 11:28 a.m., with the Infection Prevention nurse (IPN), Resident 7's medical record was reviewed. The IPN stated there was no documentation that Resident 7 was offered the COVID-19 vaccination for the 2025-2026 respiratory infection season and educated on the risks and benefits of receiving the vaccination. During a concurrent interview and record review on 1/8/2026 at 11:37 a.m., with the IPN, the Covid Vaccination log for staff was reviewed. The IPN stated the respiratory season is from October 1st to March 31st. The IPN stated it was the facility's responsibility to offer the vaccinations to all residents and staff. The IPN stated there was no documentation that staff were offered the COVID-19 vaccination for the 2025-2026 respiratory infection season and educated on the risks and benefits of receiving the vaccination. The IPN stated it was important to offer the vaccinations and educate all residents and staff on the risks and benefits of taking the vaccinations to mitigate the spread of the COVID-19 infection. The IPN stated the facility follows the California Department Public Health (CDPH -- Health Care- Associated Infections Program Recommendations dated August 2025. The CDPH recommendations, dated August 2025, indicated the Center for Medicare and Medicaid Services (CMS) requires Skilled Nursing Facilities (SNFs) to educate and offer COVID-19, influenza (contagious respiratory infection), and pneumococcal (illness caused by an infectious organism) vaccines to residents, and to educate and offer COVID-19 vaccines to health care providers. During an interview on 1/8/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated the facility educates and offers the COVID-19 vaccination to all residents and staff. The vaccination consent form is proof that residents and staff were educated and offered the vaccination. During a review of the facility's policy and procedure (P&P), titled Immunizations, COVID-19, May 2021, the P&P indicated to minimize the risk of resident acquiring, transmitting, or experiencing complications from COVID-19 by assuring that each resident: is informed about the benefits and risks of immunizations.has the opportunity to receive, unless medically contraindicated or refused or already immunized, the COVID-19 vaccine.if declined, the facility is to document the reason why resident did not receive the COVID-19 immunization in the electronic medical record.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents, Resident 31, received their meal tray at the same time as their roommates This deficient practice has the potential to compromise residents' dignity Findings: During a review of the admission Record indicated Resident 31 was admitted to the facility on [DATE] with the diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), osteomyelitis of left ankle and foot (inflammation of bone, due to infection) and non-pressure ulcer (a small open wound found on the skin) of left heel and midfoot. During a review of Resident 31's Minimum Data Set (MDS- a resident assessment tool) dated 12/20/2025, the MDS indicated the resident had the ability to make self understood and the ability to understand others. The MDS further indicated Resident 31 was independent with eating, oral hygiene (the ability to use items to clean teeth), and Resident 31 required extensive assistance on staff for transfer, dressing, toilet use, personal hygiene, and bathing. During a review of Resident's 31's physician order on 12/27/2025, the attending physician's order indicated, consistent carbohydrates, ([CCHO] bread, rice, fruit and milk), no added salt, 80 grams regular protein diet (eating a normal amount of protein each day to help the body stay strong and healthy). During a lunch observation on 1/7/2026, at 12:58 p.m., in Resident 31's room, Resident 31 did not receive his lunch tray at the scheduled meal service time, while Resident ,3 and Resident 23, received and completed lunch. During an interview on 1/7/2026, at 1:07 p.m., with Resident 31, Resident 31 stated, his meal tray was frequently delivered later than his roommate's and stated this has been an ongoing issue affecting timely receipt of meal. During a concurrent observation and interview on 1/7/2026 at 1:02 p.m., with Certified Nursing Assistant 2 (CNA 2), in Resident 31's room, observed the Registered Nurse Supervisor 1 (RNS 1) wearing gloves, mask and gown and giving lunch tray to Resident 31. CNA 2 stated that she forgot to serve the lunch tray to Resident 3. During an interview on 1/7/2026, at 3:27 p.m., with Registered Nurse Supervisor 1 (RNS 1), stated that daily meal tray service served at set times; breakfast at 7:15 a.m., lunch at 12:12 p.m., dinner at 5:15 p.m., and failure to deliver trays as scheduled may negatively impact the resident's nutrition and dignity. During an interview on 1/7/2026, at 4:06 p.m., with Dietary Supervisor (DS), stated that the warm food cart is delivered by kitchen staff to each nurses ?station 10 minutes prior to scheduled tray pass by nursing staff. failure to deliver trays as scheduled can affect resident's dignity. During a concurrent interview and record review on 1/8/2026 at 2:30 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Resident Rights, dated 3/2023 was reviewed. The facility's policy and procedure (P&P) titled, Resident Rights indicated,.7. To ensure all residents are informed of their rights. The DON stated, that Certified Nurse Assistants (CNAs) should uphold the dignity of residents by ensuring food trays are served warm to all residents same time with their roommates.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light device was within reach for one of five sampled residents (Resident 60). This failure had the potential to delay staff response and prevent Resident 60 from receiving necessary care and services. Findings: During a review of Resident 60's admission record, the admission record indicated Resident 60 was initially admitted to the facility on [DATE] and the last re-admission was on [DATE] with cataracts (a clouding of the lens of the eye), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) with left side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and left side hemiparesis (the weakness of one entire side of the body). During a review of Resident 60's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 60 had the fluctuating capacity to understand and make decisions. During a review of Resident 60's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 60 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, transfer, sit to stand, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, dressing, toilet hygiene, and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating and oral hygiene. During a concurrent observation and interview on [DATE], at 2:26 p.m., with Resident 60 in his room, Resident 60's call light was under the pillow. Resident 60 stated, he could not find the call light. Resident 60 stated, he could not move his left side due to a previous CVA, and he could not reach the call light if it was not placed on his right side. Resident 60 stated, he felt helpless when he could not find his call light because he had to wait until the staff came by to get what he needed. During an interview on [DATE], at 2:30 p.m., with the Assistant Director of Nursing (ADON) in Resident 60's room, the ADON stated, she could see the call light was placed under the pillow which Resident 60 would not be able to reach it. The ADON stated, the call light should be placed within reach of Resident 60 and it should be placed on Resident 60's right side due to his left sided weakness so he is able to use it. The ADON stated, if the call light was not within reach, Resident 60 would not be able to call for help and possibly have a fall trying to get out of bed to get help, because he was a high risk of fall. During an interview on [DATE] at 2:52 p.m., with the Director of Nursing (DON), the DON stated call lights should always be accessible and within the resident's reach. The DON stated that if the call light was not within the resident's reach, the resident would be unable to call for assistance to get his or her needs met. The DON stated, the residents who were at high risk of falling should be able to reach the call light to prevent fall related injuries. During a review of Resident 60's Care Plan Report (CPR), revised on [DATE], the CPR Focus indicated, Resident 60 had risk for falls related to CVA with left side weakness, cataract and balance problems. The CPR Interventions indicated, be sure the call light is within reach and encourage to use it to call for assistance as needed. During a review of the facility's Policy and Procedure (P&P) titled, Call Light/Bell revised 5/2023, the P&P indicated, POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures . Place the call device within resident's reach before leaving room.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician when Resident 9 refused medications for one of three sampled residents (Resident 9). This failure had the potential to result in delayed care to address the effects of Resident 9's refusal of medication. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), anemia (a condition where the body does not have enough healthy red blood cells), and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2025, the MDS indicated Resident 9 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and oral hygiene, required moderate assistance (helper does less than half the effort), and required maximal assistance (helper does more than half the effort) for toileting hygiene and bathing. During a concurrent interview and record review on 1/7/2026 at 11:44 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 9's medical record was reviewed. RNS 1 stated Resident 9 had an order to receive epoetin alpha (medication to treat anemia) injection solution 10000 unit/milliliter (mL - unit of measurement) inject one syringe in the evening every Tuesday due to resident's history of anemia. RNS 1 stated Resident 9 was diagnosed with anemia. Resident 9's Medical Administration Record for January 2026 indicated Resident 9 did not receive the epoetin alpha injection as scheduled on 12/23/2025. RNS 1 stated there was no documentation indicating the physician was notified of the missed dose. RNS 1 stated Resident 9's change of condition (COC) dated 12/29/2025 at 2:21 p.m., indicated Resident 9's hemoglobin (red blood cell) level on 12/29/2025 at 3:38 p.m., was critically low at 6.1 grams/deciliter (g/dL - unit of measurement) (reference range 12.0-15.5 g/dl). RNS 1 stated on 12/29/2025 at 11:33 p.m., Resident 9's hemoglobin level was critically low at 5.8 g/dL. RNS 1 stated the facility should have notified the physician of the missed dose of epoetin alpha injection solution 10000 unit/ml, because the missed dose of epoetin alpha could have caused her hemoglobin to drop. During an interview on 1/8/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated it was important to notify the physician when Resident 9 refused the epoetin alpha injection so the physician can decide if Resident 9's medications or plan of care should be updated. The DON stated it was important to inform the physician when an epoetin alpha medication is missed for a resident with a diagnosis of anemia because there is a risk the hemoglobin would get low and may require additional care such as a blood transfusion. During a review of the facility's policy and procedure (P&P), titled Change in Condition, dated 4/2025, the P&P indicated if, at any time, it is recognized by an one of the team members that the condition or care needs of the resident have changed, the licensed nurse or nurse supervisor should be made aware.the nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions.there will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/her clinical judgment and shall contact the physician based on the urgency of the situation.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse reporting and prevention policy by failing to report an injury of unknown origin to the California Department of Public Health (CDPH - state licensing and certification agency) and other officials which includes the Long-Term Care Ombudsman, Law Enforcement, and Licensing Agency for Based on interview and record review, for one of one sampled residents (Resident 9). Their deficient practice resulted in CDPH being unaware of the injury of unknown origin and possible abuse allegation to conduct a timely investigation. This deficient practice had the potential for information to be lost and/or forgotten. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), anemia (a condition where the body does not have enough healthy red blood cells), and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2025, the MDS indicated Resident 9 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and oral hygiene, required moderate assistance (helper does less than half the effort), and required maximal assistance (helper does more than half the effort) for toileting hygiene and bathing. During a review of Resident 9's Physician Order Summary dated 1/8/2026, the Order Summary indicated: an order Resident 9 may transfer to the general acute care hospital (GACH) due to fracture on the right leg on 12/29/2025. During a concurrent interview and record review on 1/7/2026 at 11:44 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 9's medical record was reviewed. Resident 9's change of condition (COC) dated 12/29/2025 at 2:21 p.m., indicated Resident 9 experienced swelling to the right lower thigh, and the physician ordered an x-ray (a diagnostic procedure that shows image of bones and organs). Resident 9's nursing process note dated 12/29/2025 at 10:44 p.m., indicated the x-ray results showed a fracture of the distal femur (lower thigh bone). RNS 1 stated there was no indication that Resident 9 experienced a fall to cause the fracture. RNS 1 stated the cause of Resident 9's fracture should have been reported and investigated because it was not normal to have a bone fracture. During a concurrent interview and record review on 1/8/2026 at 2:12 p.m., with the Director of Nursing (DON), Resident 9's medical record was reviewed. The DON stated it is the facility policy to report injuries of unknown origin within 24 hours if they did not know how or why the resident got an injury. The DON stated there was no report made for Resident 9's injury of unknown origin, there should have been. During a concurrent interview and record review on 1/8/2025 at 3:11 p.m. with the Administrator (ADM), the policy and procedure (P&P) titled Abuse: Prevention of and Prohibition Against, dated 12/2023, was reviewed. The ADM stated unusual occurrences should be reported to CPDH within 24 hours. The P&P indicated an injury of unknown source is used to classify an injury when all of the following are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time. The P&P indicated possible indicators of abuse include but are not limited to: bruises, skin tears and injuries of unknown source. The P&P indicated allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations. During a review of the facility's policy and procedure (P&P), titled Unusual Occurrence Reporting, dated 4/2023, the P&P indicated unusual occurrences shall be (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported by the facility within twenty-four hours either by telephone (and confirmed in writing) or facsimile to the local health officer and the Department.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Fall Management System, for one out of two sampled residents (Resident 27) by not investigating an allegation of a fall incident. This deficient practice had the potential for an actual fall for Resident 27 to not be discovered and probable causal factors to not be identified. Findings: During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of hemiplegia (cannot move or weak on one side of the body) of the right side and abnormalities of gait and mobility. During a review of Resident 27's Transfer Out Progress Note dated 11/3/2025, the Transfer Out Progress Note indicated Resident 27 was alert and oriented and able to make her needs known and Resident 27 was complaining of pain on the right-hand radiating (pain that travels from one body part to another) up to her right shoulder. The Transfer Out Progress Note indicated Resident 27 was transferred out to the General Acute Care Hospital (GACH) on 11/3/2025 for evaluation of the right-hand pain. During a review of Resident 27's GACH- Emergency Department Encounter (paperwork was received by the facility from the GACH) dated 11/3/2025, the Emergency Department Encounter indicated Resident 27 came in with a chief complaint of right arm and hand pain status post (after) a fall 7 days prior. The Emergency Department Encounter indicated Resident 27 fell backwards and fell onto hand with her right palm up. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool) dated 12/14/2025, the MDS indicated Resident 27 was cognitively intact (has sufficient judgment, planning, organization, self-control, and persistence needed to manage the normal demands of the resident's environment). The MDS indicated Resident 27 had not had any falls since readmission or since the prior assessment. During an observation and concurrent interview on 1/6/2026 at 8:27 a.m., Resident 27 stated she fell around the end of October 2025 at the facility and hurt her right hand. Resident 27's right hand was observed to be wrapped in an ace bandage (a stretchy, elastic cloth wrap used to provide firm, adjustable compression for injuries like sprains and strains, helping to reduce swelling, support joints, and improve blood flow for better healing). During an interview and concurrent record review on 1/8/2026 at 12:59 p.m., with the Director of Nursing (DON), Resident 27's GACH-Emergency Department Encounter dated 11/3/2025 was reviewed. The DON stated Resident 27 had not fallen at the facility since admission. The DON stated she reviewed the GACH- Emergency Department Encounter dated 11/3/2025 and saw Resident 27 reported a fall to the GACH but she was not aware of the incident until now. The DON stated the registered nurse (RN) supervisor re-admitting the resident back (unknown RN) to the facility post GACH transfer should have reviewed the GACH records and reported the fall to herself (the DON) so she could have investigated the reported allegation of a fall. The DON stated if a resident stated they fell, but it was not witnessed, facility staff should investigate it as an actual fall. The DON stated it was important to investigate allegations of fall because the facility needs to assess if any fall precautions needed to be implemented for the resident and so they can complete an investigation as to what happened with the fall and what caused it or if it happened to prevent repeat falls. During a review of the facility's policy and procedure (P&P) titled Fall Management System dated 4/2025, the P&P indicated a review of all fall incidents would include an investigation to determine probable causal factors.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 16) was seen in a timely manner by a Registered Dietician (RD) after an order for a RD consult was placed due to poor oral (PO) intake. This deficient practice had the potential to lead to unintentional weight loss for Resident 16 due to unaddressed poor oral intake. Findings: During a review of Resident 16's admission Record (face sheet), the admission Record indicated Resident 16 was admitted to the facility 12/3/2025 with diagnoses of encephalopathy (a broad term for any widespread brain disease or dysfunction, altering brain function due to infections, toxins, trauma, metabolic issues, or lack of oxygen) and infective endocarditis (a serious infection of the heart's inner lining (endocardium) or valves, usually caused by bacteria entering the bloodstream, though fungi or other germs can also be responsible). The admission Record did not list dementia as one of Resident 16's current diagnoses. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 16 had moderate cognitive impairment (signifies more pronounced memory and thinking issues than normal aging). The MDS indicated Resident 16 had not had any weight loss but was on a mechanically altered (change in texture of food or liquids) therapeutic diet (e.g., low salt, low cholesterol). During a review of Resident 16's Documentation Survey Report- Amount Eaten for the month of 12/2025, the Document Survey Report indicated between 12/4/2025 to 12/31/2025, Resident 16 ate 0-25% of her meal on 12 occasions, 26-50% of her meal on 17 occasions, refused meals 13 times, and the amount of food eaten was not documented for 16 occasions. During a review of Resident 16's Nutrition Evaluation and RDN (RD) Review dated 12/4/2025, the Nutrition Evaluation and RDN Review indicated Resident 16 had poor PO intake, PO intake would continue to be monitored, and nursing staff was to notify the RD of any significant changes. During a review of Resident 16's Progress Notes- SBAR (situation, background, assessment, and recommendation) Summary for Providers dated 12/8/2025, the SBAR Summary for Providers indicated Resident 16 had a change in condition (COC) due to poor PO intake with decreased appetite and fluid intake. Resident 16 was noted to only eat small portions of meals despite encouragement and assistance with feeding. During a review of Resident 16's Order Summary Report active as of 1/9/2026, the Order Summary Report indicated the physician placed an order 12/8/2025 for an RD consult. During a review of Resident 16's Documentation Survey Report- Amount Eaten for the month of 1/2026, the Document Survey Report indicated between 1/1/2026 to 1/8/2026, Resident 16 ate 0-25% of her meal on 8 occasions, 26-50% of her meal on 6 occasions, refused meals 1 time, and the amount of food eaten was not documented for 1 occasion. During an observation on 1/6/2026 at 12:36 p.m. Resident 16 was sitting in the dining room being fed her lunch and she only consumed 50% of her meal. During an interview and concurrent record review on 1/8/2026 at 12:35 p.m., RD 1 stated the last time Resident 16 was seen by a RD was on 12/4/2025 and there were no current RD progress notes after that encounter. RD 1 stated he reviewed Resident 16's Amount Eaten for the past 14 days and Resident 16 continued having poor PO intake with most days being under 50%. RD 1 stated he was not aware of the RD consult order placed on 12/8/2025 and Resident 16 should have been seen the first Thursday after the order was placed (12/11/2025) but it was not done because nursing staff did not inform RD 1 or RD 2 of the consultation. RD 1 stated nursing staff needed to inform the RDs if PO intake continued to be low. RD 1 stated it was important that the RD saw the resident in a timely manner after a new consult order was placed to address any concerns the medical team had and if the resident was not seen in a timely manner for poor PO intake it could lead to possible weight loss and malnutrition (a serious condition from deficiencies, excesses, or imbalances in nutrient intake). During an interview and concurrent record review on 1/8/2026 at 1:26 p.m., the Director of Nursing (DON) stated she reviewed Resident 16's active Physician's Orders (Order Summary Report) and noted an order for RD consult was placed on 12/8/2025. The DON stated she reviewed Resident 16's RD Consultation Notes/ Assessments and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16 was not seen by the RD after the RD consult order was placed on 12/8/2025 (last time seen by RD was 12/4/2025). The DON stated it was important that the nursing team communicated new RD consult orders to the RDs so the RDs could follow up as soon as possible and current issues could be relayed to them so they could complete their assessment and incorporate new interventions if needed. During a review of the facility's policy and procedure (P&P) titled Nutrition Status Management reviewed 4/2025, the P&P indicated if there was a significant change in the resident's condition related to weight or nutrition, the RD would make recommendations to offer additional nutrition to those residents. The P&P indicated the RD would monitor and evaluate the resident's response or lack of response to the interventions.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective pain management for one of three sampled residents (Resident 8), as evidenced by failing to assess and document Resident 8's pain level and the effectiveness of the pain medication before and after giving the pain medication. This failure had the potential to result in Resident 8 not being able to get quality sleep, decreased energy and decreased participation in activities and therapy sessions due to unrelieved pain. Findings: During a review of Resident 8's admission record, the admission record indicated Resident 8 was admitted to the facility on [DATE] with osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right ankle and foot, unstageable pressure ulcer (a full-thickness wound [caused by unrelieved pressure] where the base is hidden by dead tissue, making its true depth and severity impossible to determine until the covering is removed) on sacral area (the triangular bone [sacrum] at the base of the spine, located between the lower back [lumbar vertebrae] and the tailbone [coccyx], connecting the spine to the pelvis), and surgical removal of fingers and left toes. During a review of Resident 8's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 8 had the capacity (ability) to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 8 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, dressing, toileting hygiene, transfer, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating. During a concurrent observation and interview on [DATE], at 11:30 a.m. with Resident 8 in his room, Resident 8 had wound dressing on the left foot and amputated (the surgical removal of a limb or other body part) fingers. Resident 8 stated, he was getting treatment for infected left foot and he lost few fingers due to diabetic (a condition wherein the body is not able to process sugar, which can lead to poor wound healing) ulcers (an open sore, usually on the foot, that develops in people with diabetes due to nerve damage and poor circulation). Resident 8 stated, his pain level was 6 or 7 out of 10 in numeric pain scale (a pain screening tool, commonly used to assess pain severity at that moment in time using a 0-10 scale, with zero meaning no pain and 10 meaning the worst pain imaginable) because of the infection in his left foot. Resident 8 stated, he had constant pain and his pain level has never been zero even after taking pain medication. Resident 8 stated, he could not sleep well and did not want to participate in activities and therapy because his pain was not relieved. During a concurrent interview and record review on [DATE], 10:14 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 8's Actie Order Summary Report (OSR), dated [DATE] was reviewed. The OSR indicated, a physicians order dated [DATE] to monitor pain level using the following scale: 0=no pain, 1-3 =mild pain, 4-6 =moderate pain, and 7-10 severe pain every shift. The OSR indicated, a physicians order dated [DATE] to give Acetaminophen (Tylenol-a medication for relieving mild pain and fever) 325 milligram (mg) two tablets by mouth every four hours as needed for mild pain (pain level of 1-3) . The OSR indicated, a physicians order dated give Hydrocodone-Acetaminophen (Norco-a medication to relieve pain) 7.5-325 mg 1 tablet by mouth every four hours as needed for moderate to severe pain (pain level of 4-10) was ordered on [DATE]. RNS 1 stated, the staff should assess and document level of pain before and after providing the pain medication in Medication Administration Record to evaluate the effectiveness of medication. During a concurrent interview and record review on [DATE], at 10:35 a.m., with RNS 1, Resident 8's Medication Administration Record (MAR), dated from [DATE] to [DATE] was reviewed. The MAR indicated, monitor pain level using the following scale, 0=no pain, 1-3 =mild pain, 4-6 =moderate pain, and 7-10 severe pain every shift as follows: a. pain level of 0 was documented every shift. b. there was no pain level documented on [DATE] (PM shift :3-11 shift). The MAR indicated, give Tylenol 325 mg (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two tablets by mouth for mild pain (1-3) every four hours as needed, and it was not given. The MAR indicated, give Norco 7.5-325 mg one tablet by mouth for moderate (4-6) and severe pain (7-10) every four hours as follows: a. There was no documentation of pain level before and after giving the pain medication on MAR. b. Norco was given on [DATE] at 12:30 p.m.c. Norco was given daily except [DATE], [DATE], [DATE], [DATE], and [DATE] RNS 1 stated, the staff should have documented actual pain level before and after giving Norco in MAR per policy. RNS 1 stated, she believed that Resident 8 was having pain frequently and his pain level probably not being zero as documented due to his medical condition. During a concurrent interview and record review on [DATE], at 3:33 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 8's Minimum Data Set (MDS), dated [DATE] was reviewed. The MDS section J (Health Condition) indicated, Resident 8 received as needed pain medication and had occasionally experienced pain. The MDS section J indicated, Resident 8 occasionally pain made it hard to sleep at night and limited his participation. The MDS section J indicated, Resident 8 occasionally pain limited day to day activities and his numeric rating scale of pain was 8 out of 10. The MDSC stated, Resident 8 had severe pain that affected his sleep and limiting daily activities based on MDS assessments. The MDSC stated, if the pain was not managed effectively, it would affect resident's quality of life negatively because the resident's activity of daily life (ADL) would decline and quality of sleep at night would decline as well. During a concurrent interview and record review on [DATE], 3:15 p.m., with the Director of Nursing (DON), Resident 8's Progress Notes (PN) dated from [DATE] to [DATE] was reviewed. The PN indicated, there were no documentation of the pain level after giving Norco on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The DON stated, the pain level should be assessed and documented before and after administration of pain medication to evaluate effectiveness of medication on MAR. The DON stated, there was documentation of the pain level before giving Norco in PN, but re-assessment of the pain level after administration was not documented consistently. The DON stated, she was not sure why some of the pain level assessments were documented on PN and it should be documented in MAR. The DON stated, if the pain is not relieved effectively, the staff should notify the doctor. DON stated accurate pain assessment is a critical element to managing pain effectively. DON stated controlling pain is important to improve or maintain resident's quality of life, daily activity, sleeping, and healing process. During a review of Resident 8's Care Plan Report (CPR), revised [DATE], the CPR Focus indicated, pain related to surgical incision, wound, and infection. The CPR Goal indicated, Resident 8 will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through [DATE]. The CPR Interventions indicated, follow pain scale to medicate as ordered, monitor/document pain characteristic (quality, severity, location, onset, and duration), and pain assessment every shift. During a review of the facility's Policy and Procedure (P&P) titled, Pain Recognition and Management, revised 4/2025, the P&P indicated, Policy : It is the policy of this to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. Procedure: 3. Pain will be identified and documented in the electronic health record (EHR) a. Using a scale of 1-10 is most common. b. Medication(s) received, refused and response to medication will be documented on the Electronic Medication Administration Record (e-MAR). c. If the pain management program is not effective, the licensed nurse will contact the resident's physician . 5. Monitoring: a. Monitor pain status every shift using either the numerical pain rating (1-10). b. Monitor for effectiveness of interventions and/or adverse consequences. c. Consult physician for additional interventions if pain is not relieved by current orders.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to document medication administration for one of three sampled residents (Resident 6). This failure had the potential to result in Resident 6 receiving duplicate doses of acetaminophen (medication used to reduce pain or fever) which places residents at risk for liver problems due to taking too much acetaminophen. Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects brain function) and kidney disease. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 11/4/2025, the MDS indicated Resident 6's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 6 required supervision when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, required maximal assistance (helper does more than half the effort) for toileting hygiene and bathing, and was dependent for lower body dressing. During a review of Resident 6's Physician Order Summary dated 1/8/2025, the Order Summary indicated an order for Acetaminophen Oral Tablet 325 milligrams (MG- a unit of measurement of weight), give two tablets by mouth every four hours as needed for generalized pain, not to exceed (nte) 3 grams (G- a unit of measurement)/24 hours of any acetaminophen sources, starting 1/8/2026. During a concurrent observation and interview on 1/7/2026 at 9:08 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed administering two tablets of acetaminophen to Resident 6. LVN 2 stated he administered two tablets of acetaminophen for Resident 6's complaint of pain. During a concurrent interview and record review on 1/7/2025 at 12:29 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 6's Medication Administration Record (MAR) for January 2026 was reviewed. RNS 1 stated there was no documentation indicating Resident 6 received acetaminophen on 1/7/2025. RNS 1 stated It was important to document any medication administration as soon as it is administered to decrease the risk of medication overdose. During an interview on 1/8/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated it was important to document medication administration when the medication is administered. The DON stated if an acetaminophen administration was not documented, there was a risk that Resident 6 could receive an additional dose of acetaminophen. The DON stated if a resident is given duplicate doses of acetaminophen, it can place a resident at risk of liver problems. According to the Food and Drug Administration ([FDA] federal agency responsible for protecting public health by regulating the safety, effectiveness, and labeling of foods, drugs etc.) taking too much acetaminophen, also known as an acetaminophen overdose, is unsafe and can lead to liver failure and death. (https://www.fda.gov/drugs/information-drug-class/acetaminophen) During a review of the facility's policy and procedure (P&P), titled Medication Administration - General Guidelines, dated January 2017, the P&P indicated the individual who administers the medication dose records the administration on the resident's MAR after the medication pass is completed. At the end of each medication pass, the person administering the medications reviews the MAAR to ensure necessary doses were administered and documented.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of six sampled residents (Resident 16)'s diagnoses list was updated to reflect her dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells) diagnosis. As a result of this deficient practice, Resident 16 was receiving medications for a dementia diagnosis that was not listed as one of her current problems. Findings: During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses of encephalopathy (a broad term for any widespread brain disease or dysfunction, altering brain function due to infections, toxins, trauma, metabolic issues, or lack of oxygen) and infective endocarditis (a serious infection of the heart's inner lining (endocardium) or valves, usually caused by disease causing organisms). The admission Record did not list dementia as one of Resident 16's current diagnoses. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 16 had moderate cognitive impairment (signifies more pronounced memory and thinking issues than normal aging). The MDS indicated Resident 16 had dementia although it was not listed as her current diagnosis. During an interview and concurrent record review on 1/8/2026 at 3:21 p.m., with the Director of Nursing (DON), Resident 16's current and active physicians orders as of 1/8/2026 (Order Summary Report) were reviewed. The DON stated Resident 16 was receiving Memantine 5milligrams twice daily for dementia. The DON stated she reviewed Resident 16's current diagnoses list as of 1/8/2026 and dementia was not listed on the current diagnoses list. The DON stated it was important to have an updated diagnoses list to reflect all current diagnoses to ensure the residents were receiving the proper treatments and medications to address the current list of diagnoses. The DON stated the potential outcome of receiving medication for a disease that was not listed on the diagnosis list was that the resident could be receiving improper treatment. During an email exchange on 1/13/2025, the administrator (ADM) confirmed the facility did not have a policy and procedure (P&P) for accuracy of documentation.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control measures by failing to ensure Restorative Nurse Aide (RNA -provides specialized care to help patients recover and keep their functional abilities) 1 wore Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) properly for one of three sampled residents (Resident 71) who was on Enhanced Barrier Precaution (EBP-an infection control measures, primarily in nursing homes, requiring staff to wear gowns and gloves during high-contact care for residents with multidrug-resistant organisms or increased risk factors like wounds/devices, expanding beyond Standard Precautions to prevent MDRO spread where direct contact is likely).This failure had the potential to result in compromised infection control measures and the spread of infection among residents, staff, and visitors.Findings:During a review of Resident 71's admission record, the admission record indicated Resident 71 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with sepsis (a life-threatening blood infection), acute (sudden onset) pyelonephritis (a serious bacterial infection and inflammation of the kidney), and chronic kidney disease (the kidneys have become damaged over time).During a review of Resident 71's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 71 had fluctuating (irregularly varying) capacity to understand and make decisions.During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 71 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, getting dressed, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, toilet hygiene, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating and oral hygiene.During a concurrent observation and interview on [DATE], at 10:19 a.m., with RNA 1, there was an EBP sign on the wall above Resident 71's bed. RNA 1 was performing Active Assisted Range of Motion (AAROM-a type of exercise where a person moves a joint as much as they can, but receives help from a therapist, equipment (like a strap or stick), gravity, or their other limb to achieve a greater range of motion) on Resident 71's right leg. RNA 1 was wearing a face mask and gloves. RNA 1 was not wearing a gown. RNA 1 was holding Resident 71's right leg up and his nursing uniform was touching the bed linen. RNA 1 stated, he did not know that Resident 71 was on EBP because of a suprapubic catheter (a thin tube inserted through a small opening in the lower abdomen directly into the bladder to drain urine). RNA 1 stated, he should have worn the gown because AAROM required high contact with Resident 71, and high contact with out a gown could to spread infection.During an interview on [DATE], at 10:35 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated, the staff should wear a mask, a gown, and gloves before performing high contact activities such as bathing, hygiene care, changing, transferring, and providing AAROM to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) when they were caring for the residents who were on EBP.During an interview on [DATE], at 2:58 p.m., with the Director of Nursing (DON), the DON stated, PPE should be worn correctly according to different types of isolation. The DON stated, Resident 71 met the criteria for EBP due to a suprapubic catheter which was an invasive line. The DON stated EBP required wearing a mask, gown, and gloves before performing high contact resident care that required touching the residents. The DON stated, the staff must wear proper PPE to protect themselves and the vulnerable residents in the facility.During a review of Resident 71's Order Summary Report (OSR), dated [DATE], the OSR indicated, EBP and PPE required for high contact care activities due to an indwelling medical device/suprapubic catheter ordered on [DATE]. The OSR indicated, RNA to perform AAROM of bilateral lower extremities in all available directions three times a week, ordered [DATE].During a review of Resident 71's Care Plan Report (CPR), revised [DATE], (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the CPR Focus indicated, Resident 71 had suprapubic catheter. The CPR Interventions indicated, use Enhanced Barrier Precaution. During a review of the facility's Policy and Procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated, Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions. Procedure: 3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gowns and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs).		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' rooms had 80 square feet ([sq ft], a unit of measurement) per resident in multiple resident rooms. This deficient practice had potential for affecting the residents' quality of life, safety, health and provision of care. Findings: During a record review of the facility's client accommodation analysis form, the following resident rooms measured as follows: room [ROOM NUMBER], 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 17, 19, 21, 24, 25, 27, 29, 37, and 39 accommodated three residents per room and it was measured 223 sq. room [ROOM NUMBER], 18, 20, 22, 28, 30, 31, 32, 33, 34, 35, and 36 accommodated two residents per room and it was measured 144 sq ft. During an interview with the Administrator (ADM) on 1/8/2026 at 1:30 p.m., the ADM stated the importance of having an appropriate room size for the residents was that the facility was their home, and the facility must make sure residents have enough space for comfort and be able to move around in the room. The ADM stated the rooms must have a home-like environment and have enough space to complete daily activities. The ADM stated if the rooms are not appropriate size, and if the residents are not able to transfer safely from bed to chair, they can fall. The ADM stated the residents may be stuck in the room and unable to get out if they are in a wheelchair. It can be unsafe for staff to try to maneuver the resident in the room as well. During an observation from 1/5/2026 to 1/8/2026, there were no issues observed with resident's needs, and health, and safety were not affected by the room size. The Department is recommending continuation with the room waiver.		