

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Broadway Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E. Broadway San Gabriel, CA 91776	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility staff failed to protect the confidential personal information for one of 18 sampled residents (Resident 9) by not closing the computer screen after looking up Resident 9's medical information at the Nursing Station when there were other staff, residents, and visitors in the area.</p> <p>This deficient practice had the potential to expose Resident 9's medical records to others and violated the resident's right for privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative).</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/27/2024 and readmitted on [DATE] with diagnoses that included but not limited to acute on chronic combined systolic and diastolic congestive heart failure (a sudden worsening of a pre-existing chronic condition where the heart struggles to both pump blood effectively and fill properly due to stiffness, leading to fluid build-up and congestion in the body), acute respiratory failure with hypoxia (a condition where the lungs are unable to absorb enough oxygen into the blood), acute pulmonary edema (a life-threatening condition that occurs when fluid builds up in the lungs, making it difficult to breathe) and chronic pulmonary edema (a condition where fluid builds up in the lungs over time, making it difficult to breathe), pleural effusion (a condition where too much fluid builds up in the pleural cavity [the space between the lungs and chest wall]), and pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi).</p> <p>During a record review of Resident 9's History and Physical (H&P), dated 1/14/2025, the H&P indicated Resident 9 has the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2024, indicated Resident 9 required setup or clean-up assistance (Helper sets up or cleans up, resident completes activity) with eating, oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for shower or bathing self.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN1) on 1/21/2025 at 9:45 AM, observed LVN1 log into the computer to review Residents 9's medical information. After a few minutes, observed LVN1 get up off the chair where she was sitting and walked away leaving the computer screen open displaying Resident 9's admitting orders.</p> <p>During a concurrent observation and interview with CNA1 on 1/21/2025 at 09:55 AM, CNA1 confirmed the computer screen which had the residents' information was left open and unattended. There were other residents and family members sitting at the nursing area near the computer with the screen left open.</p> <p>During concurrent interview with CNA1 on 1/21/2025 at 9:59 AM, CNA1 stated, Anyone walking by can see the resident's medical information. It is the resident's private information. Residents' private information is HIPAA (Health Insurance Portability and Accountability Act -a federal law that protects resident's health information and gives them more control over how their information is used) and we know we are not supposed to leave the computer open. We need to log off if we are to walk away. It is HIPAA violation if she walked away.</p> <p>During an interview with the Director of Nursing (DON) on 1/21/2025 at 10:20 AM, the DON stated, The staff have education regarding HIPAA. An example of not respecting HIPAA is if any staff talks about resident information anywhere in the facility including at nursing station and if there are other people around that are not part of the medical team like a family member or other residents. It also applies to having computer screen with residents' information open. Anybody can see it if they walk by, and the staff walk away. The staff know they are supposed to turn off the computer or close the computer screen before they walk away. The DON stated it was important to protect the residents' confidentiality and privacy. The DON also stated, We give inservices about HIPAA often, the nurses should know this, it's fundamentals for them to know. We all need to maintain HIPAA compliance.</p> <p>During an interview with Director of Staff Development (DSD) on 1/24/2025 at 9:41 AM, DSD stated, I give the staff in services (continuing education and trainings). All staff are responsible to keep the resident's privacy including closing a computer screen with the resident's medical information. It's a direct violation of HIPAA.</p> <p>During a review of the facility Policy and Procedure (P&P) titled, Release of Information, revised November 2009, the P&P indicated, Our facility maintains the confidentiality of each resident's personal and protected health information.</p> <p>1. Each resident will receive confidential treatment of his or her personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of a transfer to another healthcare institution or as required by current HIPAA law.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on interview and record review, the facility failed to ensure accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) for one (1) of five (5) sampled residents (Resident 35) by failing to include the resident's diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>This deficient practice had the potential for the facility to not develop and implement an individualized care plan, which could negatively affect Resident 35's overall well-being.</p> <p>Findings:</p> <p>During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 35's General Acute Care Hospital (GACH) Emergency department history and physical (H&P), dated 2/12/2024, the H&P indicated Resident 35 has a medical history of schizophrenia.</p> <p>During a review of Resident 35's Order Summary Report, dated 1/22/2025, the report indicated an order for Seroquel (medication to treat several kinds of mental health conditions) oral table 50 milligrams (mg, unit of measurement) at bedtime for schizophrenia manifested by striking out towards staff, ordered on 9/8/2024.</p> <p>During a review of Resident 35's Quarterly MDS, dated [DATE], the MDS indicated Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 35 had episodes of feeling down, depressed, or hopeless. The MDS indicated Resident 35 required supervision (helper provides verbal cues as resident completes the activity) with eating. The MDS indicated Resident 35 required partial assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 35 required substantial assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear. The MDS did not indicate schizophrenia as Resident 35's active diagnosis. The MDS indicated Resident 35 received antipsychotic (medication to treat the symptoms of schizophrenia) on a routine basis.</p> <p>During a review of Resident 35's Quarterly MDS, dated [DATE], the MDS did not indicate schizophrenia as Resident 35's active diagnosis.</p> <p>During a concurrent record review and interview on 1/22/2025 at 2:23 PM with Registered Nurse 2 (RN 2), Resident 35's medical records was reviewed. RN 2 stated Resident 35 is being treated with Seroquel for schizophrenia, therefore schizophrenia should be documented as an active diagnosis. RN 2 verified Resident 35's MDS dated [DATE] did not indicate schizophrenia as an active diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/22/2025 at 3:03 PM with MDS nurse (MDSN), she stated schizophrenia cannot be coded in Resident 35's MDS because there was not enough documentation such as comprehensive psychiatrist (physician who specializes in mental health) test (written records of a patient's mental health treatment) that Resident 35 was diagnosed with schizophrenia.</p> <p>During a concurrent record review and interview on 1/23/2025 at 3:38 PM with RN 1, Resident 35's medical records was reviewed. RN 2 stated Resident 35 has an order of Seroquel for schizophrenia since 3/12/2024. RN 2 stated Resident 35 has been seen by Psychiatrist while in the facility on the following dates:</p> <p>4/9/2024</p> <p>6/4/2024</p> <p>8/13/2024</p> <p>9/10/2024</p> <p>10/22/2024</p> <p>11/19/2024</p> <p>12/17/2024</p> <p>1/14/2025</p> <p>During a concurrent record review and interview on 1/24/2025 at 12:23 PM with the Director of Nursing (DON), the DON stated the MDS is a reflection of the resident's current status that is why it is being done upon admission, quarterly, annually, and when there is a significant change of condition. The DON stated the current MDS assessment will assist the staff in developing an appropriate plan of care. The DON stated schizophrenia is an active diagnosis of Resident 35 because the resident is being treated with Seroquel for it. The DON verified that schizophrenia was not and should have been coded in Resident 35's MDS.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, Resident assessments, revised in October 2023, the P&P indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team (a group of professionals that work together to coordinate care) conducts timely and appropriate resident assessments. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to revise the care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) for one (1) of 18 sampled residents (Resident 158) in accordance with the facility policy by failing to update Resident 158's care plan on stage 2 pressure ulcer (damage to the skin and underlying soft tissue caused by prolonged pressure) to include Resident 158's non-compliance of interventions.</p> <p>This deficient practice had the potential for Resident 158's pressure ulcer to worsen or develop new pressure injury.</p> <p>Findings:</p> <p>During a review of Resident 158's Admission record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 158 was originally admitted to the facility on [DATE]. Resident 158's diagnoses included stage two pressure ulcer of sacral region (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), urinary tract infection (UTI- an infection in the bladder/urinary tract) and sepsis (a life-threatening blood infection).</p> <p>During a review of Resident 158's Admission Data Tool, dated 1/1/2025, indicated Resident 158 has a pressure ulcer. The resident's Data Tool also indicated Resident 158 required one-person physical assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed), and Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) transferring.</p> <p>During a review of Resident 158's care plan (CP) initiated on 1/1/2025, the CP indicated Resident 158 has actual skin break down on the sacrococcyx stage 2. The CP was revised on 1/20/2025, to include Resident 158 is at risk for delayed & decline wound healing due to non-compliance, refusal to be repositioned or up on cushion wheelchair, prefer to stay in bed all the times and regression of skin breakdown to stage 3. The CP indicated the CP goal is for Resident 158 to not have signs and symptoms of complications with skin breakdown, the CP interventions included the following:</p> <p>Notify resident/responsible party of skin status, initiated on 1/1/2025.</p> <p>Keep area clean and dry, avoid skin contact, initiated on 1/1/2025.</p> <p>Administer medication as ordered to promote wound healing, initiated on 1/5/2025, revised on 1/20/2025.</p> <p>Assisted to turn and reposition every 2 hours as tolerated, initiated on 1/5/2025.</p> <p>Treatment as ordered, initiated on 1/5/2025, revised on 1/20/2025.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 158's interdisciplinary team (IDT, a group of professionals who work together to assess and care for residents) wound management assessment, dated 1/2/2025, indicated Resident 158 was newly admit resident, with pressure ulcer, described to be stage 2 at sacrococcyx (the area just above the buttocks) measured at 2.5 centimeters (cm, unit of measurement) by 2 cm.</p> <p>During a review of Resident 158's IDT wound management assessment, dated 1/11/2025, indicated Resident 158 current Plan of Care remains appropriate to manage and promote the healing process. No changes needed at this time.</p> <p>During a review of Resident 158's IDT wound management assessment, dated 1/18/2025, indicated Resident 158 current Plan of Care remains appropriate to manage and promote the healing process. No changes needed at this time. It also indicated Resident 158 required 1 staff assistance for bed mobility, turning and repositioning. Resident was assisted to turn and reposition every 2 hours as tolerated, has episode of refusal to be repositioned and up on cushioned wheelchair.</p> <p>During a review of Resident 158's IDT wound management assessment, dated 1/20/2025, indicated Resident 158 stage 2 pressure ulcer progressed (pressure ulcer worsened) to stage three (3) a full thickness skin loss where the underlying tissue within the wound. It indicated Resident 158 is non-compliance, at risk for wound decline & delayed healing. Resident 158 was refusing to be repositioned and up on cushioned wheelchair, prefer to stay in bed most of the time.</p> <p>During a concurrent observation and interview on 1/22/2025 at 9:59 AM with Resident 158, in the hallway, Resident 158 was observed sitting in wheelchair. Resident 158 stated she does not want to be seated in the wheelchair, but staff bribed (persuaded) her with soda, because that was the family instruction to staff for Resident 158 to cooperate with the care. This was the reason why she agreed to get up from bed and be seated in the chair.</p> <p>During an interview on 1/23/2025 at 10:02 AM with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 158 was cooperative with her today, but CNA 1 stated that Resident 158 has episodes of refusal of care in the past. CNA 1 stated that when a resident refused care, it will be reported to charge nurse so they can discuss what other type of care can be provided.</p> <p>During a concurrent record review and interview on 1/23/2025 at 10:51 AM with Treatment Nurse (TN), Resident 158's medical records was reviewed. TN stated Resident 158 was admitted on [DATE] with open wounds, sacral stage 2 pressure ulcer. TN stated Resident 158's sacral pressure ulcer became stage 3 on 1/20/2025 when wound consultant came to check Resident 158. TN stated Resident 158 has episodes of refusing to be turned while in bed and refusing get out of bed and be seated in wheelchair that's why Resident 158's stage 2 sacral pressure ulcer worsened to a stage 3. TN stated Resident 158's care plan was only revised on 1/20/2025 after wound consultant diagnosed Resident 158's sacral pressure ulcer to stage 3. TN stated that updating or revising resident's care plans was important to ensure that the staff taking care of Resident 158 would have the knowledge about the type of care to provide to Resident 158.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview on 1/23/2025 at 2:58 PM with Licensed Vocational Nurse (LVN) 1, Resident 158's care plan was reviewed. LVN 1 stated Resident 158 is not cooperative with care sometimes, and assigned CNAs would let her know that Resident 158 would refuse to get up from bed, or to be turned and repositioned while in bed. LVN 1 verified Resident 158's non-compliance with care was only added in Resident 158's care plan on 1/20/2025, LVN 1 added that it should have been added when Resident 158 started to show non-compliance with care by refusing to be turned or repositioned. LVN 1 stated all licensed nurses can initiate and revised care plan.</p> <p>During an interview on 1/23/2025 at 3:27 PM with Registered Nurse (RN) 1, RN 1 stated she was aware of Resident 158's non-compliance with care, RN 1 stated Resident 158 did not start refusing to be turned or repositioned on 1/20/2025. RN 1 stated non-compliance care plan should have been added when staff noticed Resident 158 refusing care, and interventions such as offering soda per family's instructions should have been added as intervention for Resident 158 to cooperate with care. RN 1 stated Resident's representative or family's input should have been documented in the care plan because care plan involves the Resident and Resident's family or representatives.</p> <p>During a record review of Facility's Policy and Procedure titled Care Plans, Comprehensive Person Centered, revised in March 2022, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. It indicated the interdisciplinary team reviews and updates the care plan:</p> <ul style="list-style-type: none"> a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; <p>It also indicated the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility failed to ensure professional standards of quality for administering oxygen was met for one (1) of one sampled resident (Resident 9) by failing to ensure Resident 9 was administered oxygen by a licensed nurse and not by a certified nurse assistant.</p> <p>This deficient practice had the potential to result in provision of unnecessary/incorrect care for Resident 9, which could result to harm.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/27/2024 and readmitted on [DATE] with diagnoses that included but not limited to acute on chronic combined systolic and diastolic congestive heart failure (a sudden worsening of a pre-existing chronic condition where the heart struggles to both pump blood effectively and fill properly due to stiffness, leading to fluid build-up and congestion in the body), acute respiratory failure with hypoxia (a condition where the lungs are unable to absorb enough oxygen into the blood), acute pulmonary edema (a life-threatening condition that occurs when fluid builds up in the lungs, making it difficult to breathe) and chronic pulmonary edema (a condition where fluid builds up in the lungs over time, making it difficult to breathe), pleural effusion (a condition where too much fluid builds up in the pleural cavity [the space between the lungs and chest wall]), and pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi).</p> <p>During a record review of Resident 9's History and Physical (H&P), dated 1/14/2025, the H&P indicated Resident 9 has the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2024, the MDS indicated Resident 9 required setup or clean-up assistance (Helper sets up or cleans up, resident completes activity) with eating, oral/toileting/personal hygiene, upper and lower body dressing and putting on/taking off footwear and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for shower or bathing self.</p> <p>During a review of Resident 9's Care Plan initiated on 8/13/2024 with revision date of 1/16/2025, the care plan indicated Resident is at risk for altered respiratory status difficulty breathing related to pulmonary edema, acute respiratory failure, acute CHF, and pleural effusion. Staff interventions included were to provide oxygen as ordered and to give medications as ordered by physician.</p> <p>During a review of Resident 9's Order Summary Report, dated 1/13/2025, the report indicated a Physicians order for Oxygen at 2 to 5 liters per minute via nasal cannula continuously for diagnosis of hypoxia (low levels of oxygen in your body tissues) related to CHF every shift.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/21/25 at 9:37 AM in Resident 9's room, observed Certified Nurse Assistant 1 (CNA1) assisting Resident 9 from bedside commode (a portable toilet that can be used when someone is unable to walk to the bathroom) back to bed. Resident 9 was observed without an oxygen and was short of breath. CNA1 asked Resident 9 if Resident 9 wanted oxygen. Resident 9 responded yes. Observed CNA1 place the nasal cannula (a medical device that supplies oxygen to a patient through their nose) to the resident's nostrils and proceeded to turn the oxygen concentrator (a device that provides oxygen to people who have difficulty breathing) at 5 liters (a unit of measurement) per minute (min). Resident 9 whispered she was still short of breath even with the oxygen. CNA1 observed walking out of Resident 9's room and stated she would be back and would call the nurse.</p> <p>During an interview with LVN1 on 1/21/25 at 9:49 AM, LVN1 stated CNA1 had just given Resident 9 a shower. Per LVN1, CNA1 was supposed to check Resident 9's Resident 9's oxygen level and put the oxygen right back. LVN1 stated CNA1 can put the nasal canula on Resident 9 but she has to come and get the nurse to go and check the machine for the oxygen level. LVN1 stated, The CNA cannot turn on the machine because they do not know the oxygen order. We have to check the oxygen level after she (Resident 9) has been put on oxygen.</p> <p>During an interview with CNA1 on 1/21/25 at 9:55 AM, CNA1 stated she gave Resident 9 a shower that lasted about 15 to 30 minutes. Per CNA1 if a resident has to be given oxygen, CNA1 needed to wait for the approval from the licensed nurse. Per CNA1, Resident 9 told her when she was brought back to her room that she was short of breath. CNA1 stated, I turned on the oxygen machine and the level was from 1 to 5 liters but I am not sure of the doctor's order. The charge nurse usually checks the chart. I don't think its ok for me to have done that even though she was complaining of shortness of breath. As a CNA, I am just supposed to set up the nasal cannula, the charge nurse was supposed to turn on the machine. I am not supposed to turn the oxygen machine on because I am not sure of the oxygen level order she was supposed to have. If the oxygen is too much, she could easily get too much oxygen and make the breathing worse.</p> <p>During an interview with the Director of Nursing (DON) on 1/21/25 at 10:16 AM, the DON stated, All staff get in services for oxygen administration. The CNA was supposed to call charge nurse, not put the oxygen back on, not even the nasal cannula or turn on the oxygen machine unless resident requested for it. It's not acceptable, this is delivering oxygen. It is like a medication; it should only be administered by the licensed nurse because the CNA doesn't know the patient's diagnosis. What if the patient had Chronic obstructive pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems)? That means the patient can only tolerate a certain amount of oxygen, and only an amount can be administered. It could bring possible harm to the patient. The DON also stated that the resident's oxygen levels need to be checked by the licensed nurse and not the CNA because they are more knowledgeable.</p> <p>During an interview with LVN2 on 1/23/2025 at 3:30 PM, LVN2 stated that CNAs are not allowed to place nasal cannulas on the residents or start oxygen machine. LVN 2 stated, Only the licensed nurses are supposed to do that. LVN2 stated, Even us as LVNs have certain limitations on what we can do when it comes to medications or oxygen administration, we can only place the resident on 2 liters of oxygen at a time to start.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Director of Staffing Development (DSD) on 1/24/2025 at 9:41 AM, DSD stated, Regulating an oxygen tank is not within CNA's job description and should be done by licensed nurses only because oxygen therapy is like a medicine that only licensed nurses can administer per Doctor's order. The CNA can help bring the oxygen tank and she can help with the setup, she can adjust the nasal cannula to the resident's face but not tighten it around the neck. The CNA can also adjust the nasal cannula if the resident's nostril is out and not receiving oxygen. It is not acceptable for a CNA to turn on the oxygen machine or regulate oxygen levels after placing the nasal cannula on the resident. The responsible staff to perform those duties is the license nurse, meaning an LVN, RN or CN. If the CNA turned the machine to 5 liters while the patient had the nasal cannula on, it might be hazardous to the resident. For example, it can place the resident in respiratory distress because the CNA does not know about the oxygen level or the doctors' orders.</p> <p>During a review of the facility's undated document with the description of Certified Nurse Assistant essential duties and responsibilities, the document indicated,</p> <p>POSITION SUMMARY</p> <p>The purpose of your job position is to provide each resident with routine daily nursing care in accordance with the resident's assessment plan along with current federal, state, and local standards that govern the facility, and as directed by your supervisors.</p> <p>The Certified Nurse Assistant will . demonstrate patience, initiative, and willingness to assist residents that may be difficult. They will relate all pertinent information concerning a resident's condition to a charge nurse when required. They will be committed to always doing the right thing.</p> <p>During a review of the facility undated document with the description of Charge Nurse Supervisor essential duties and responsibilities, the document indicated,</p> <p>Purpose of Your Job Position</p> <p>The primary purpose of your job position is to provide direct nursing care to the residents, and to supervises the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing Services or Nurse Supervisor to ensure that the highest degree of quality care is maintained at all times.</p> <p>Delegation of Authority</p> <p>As Charge Nurse you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties.</p> <p>Duties and Responsibilities</p> <p>-Ensure that all nursing personnel assigned to you comply with the written policies and procedures established by this facility.</p> <p>-Ensure that all nursing service personnel are in compliance with their respective job descriptions</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Drug Administrative Functions</p> <ul style="list-style-type: none"> o Prepare and administer medications as ordered by the physician o Ensure that all nurse aide trainees are under the direct supervision of a licensed nurse o Ensure that direct nursing care be provided by a licensed nurse, a certified nursing assistant, and/or a nurse aide trainee qualified to perform the procedure <p>During a review of the facility Policy and Procedure (P&P) titled, Oxygen Administration, revised October 2010 indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.</p> <p>Equipment and Supplies</p> <p>The following equipment and supplies will be necessary when performing this procedure.</p> <p>4. No Smoking/Oxygen in Use signs</p> <p>Assessment</p> <p>Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following:</p> <ol style="list-style-type: none"> 1. Signs or symptoms of cyanosis (blue tone to the skin and mucous membranes) 2. Signs or symptoms of hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (tracheal irritation, difficulty breathing, or slow, shallow rate of breathing) 4. Vital signs 5. Lung sounds <p>Steps in the Procedure</p> <ul style="list-style-type: none"> -Place an Oxygen in Use sign on the outside of the room entrance door -Place an Oxygen in Use sign in a designated place on or over the resident's bed -Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2-3 liters/min -Place appropriate oxygen device on the resident (mask, nasal cannula and/or nasal catheter). -Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered <p>(continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Preparation and General Guidelines effective date of October 2017 indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview and record review, the facility failed to ensure one of 18 sampled residents (Resident 9) was provided a communication device with the language that the Resident 9 preferred.</p> <p>This deficient practice prevented Resident 9 from communicating with the staff and had a potential to delay receiving appropriate care/treatment Resident 9 needed.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/27/2024 and readmitted on [DATE] with diagnoses that included but not limited to acute on chronic combined systolic and diastolic congestive heart failure (a sudden worsening of a pre-existing chronic condition where the heart struggles to both pump blood effectively and fill properly due to stiffness, leading to fluid build-up and congestion in the body), acute respiratory failure with hypoxia (a condition where the lungs are unable to absorb enough oxygen into the blood), acute pulmonary edema (a life-threatening condition that occurs when fluid builds up in the lungs, making it difficult to breathe) and chronic pulmonary edema (a condition where fluid builds up in the lungs over time, making it difficult to breathe), pleural effusion (a condition where too much fluid builds up in the pleural cavity [the space between the lungs and chest wall]), and pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi).</p> <p>During a record review of Resident 9's History and Physical (H&P), dated 1/14/2025, the H&P indicated Resident 9 has the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2024, indicated Resident 9 preferred language is 1 and requested an interpreter to communicate with a doctor or health care staff. Resident 9 required setup or clean-up assistance (Helper sets up or cleans up, resident completes activity) with eating, oral/toileting/personal hygiene, upper and lower body dressing and putting on/taking off footwear and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for shower or bathing self.</p> <p>During a review of Resident 9's Care Plan initiated 3/04/2024 with a revision date of 8/17/2024, the care plan indicated, The resident has a communication problem . Diagnosis of Dementia. Primary language is non-English. Staff interventions indicated were to provide translator as necessary to communicate with the resident. Translator is staff and/or family members.</p> <p>During initial observation of Resident 9 on 1/21/25 at 9:24 AM, Resident 9 was not in the room. There was no communication or picture board at bedside noted.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview with Licensed Vocational Nurse (LVN1) on 1/21/25 at 9:41 AM, LVN1 walked inside Resident 9's room and asked in a language the resident does not understand, if Resident 9 was short of breath. Resident 9 stated in her own language she was short of breath. LVN1 stated she did not understand what Resident 9 was saying and that she would get someone to translate so she could communicate with the resident. Observed LVN1 leave Resident 9's room to look for a translator.</p> <p>During observation of Infection Prevention (IP) nurse on 1/21/25 at 9:44AM, IP walked inside Resident 9's room and asked Resident 9 in language the resident does not speak or understand, if she was breathing ok. Resident 9 stated she was short of breath.</p> <p>During an interview with Director of Nursing (DON) on 1/23/25 at 12:41 PM, DON stated it was not acceptable for LVN1 to walk out of Resident 9's room when Resident 9 was complaining of shortness of breath if LVN1 did not understand what Resident 9 was saying. The DON confirmed Resident 9 was at risk of harm by being left alone in the room while complaining of shortness of breath. Per DON the facility has a phone service they use for translation and staff should use this to communicate with residents. The DON stated if not the staff can use staff who spoke the same language as the resident or family member to help them translate.</p> <p>During a concurrent interview and record review with DON on 1/23/25 at 12:50 PM, the DON confirmed that Resident 9's face sheet indicated the primary language in the MDS is not the same as what is the resident's preferred language. The DON stated he was not aware if there was a communication or picture board at Resident 9's bedside for staff and the resident to use to communicate.</p> <p>During a concurrent observation in Resident 9's room and interview with Family 1 and Resident 9 on 1/23/25 at 1:09 PM, there were no communication or picture boards in the resident's room. Family 1 stated Resident 9's preferred language to speak in her own language. Family 1 stated she would like more staff available to communicate with Resident 9 in her language.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Translation and/or interpretation of Facility Services, revised July 202, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility.</p> <p>6. interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information.</p> <p>7. Family members and friends shall not be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. If family or friends are used to interpret, the resident must provide written consent for disclosure of protected health information.</p> <p>During a review of the facility's P&P titled, Homelike Environment, revised February 2021 indicated, Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on observation, interview, and record review, the facility failed to provide grooming services for one (1) of 18 sampled residents (Resident 23) who was dependent with activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), in accordance with the facility's policy.</p> <p>This deficient practice resulted in Resident 23 having long and jagged (having rough, sharp points protruding) fingernails, potentially leading to skin injury, infection, and scarring.</p> <p>Findings:</p> <p>During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis which included lack of coordination, sepsis (a serious condition in which the body responds improperly to an infection), and dysphagia (swallowing difficulties).</p> <p>During a review of Resident 23's Annual History and Physical (H&P) dated 10/31/2024, the H&P indicated Resident 3 was non-verbal (a person who didn't or doesn't speak), only occasionally speaking a confused random word or short sentence in response to hearing her name. Resident 3 did not make eye contact or follow instruction and was totally dependent on staff assistance with ADL's. H&P also indicated nurses would continue to assist with ADL's.</p> <p>A review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 23 cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 23 was dependent on personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands.</p> <p>During a concurrent observation and interview on 1/23/2025 at 8:28 AM with certified nursing assistant 3 (CNA) 3 in Resident 23's room, Resident 23 was observed. CNA3 stated that Resident 23's left and right nails were long, rough, sharp, and not smooth. CNA 3 also stated Resident 23 had multiple wounds on the right leg since Resident 23 has the habit of scratching.</p> <p>During a concurrent interview and review on 1/23/2025 at 9:23 AM with the director of staff and development (DSD), Resident 23's Order Summary report date ordered 1/12/2025 was reviewed. The DSD stated the order summary indicated Scattered scratches at right lower leg. Cleanse with Normal Saline Solution (NSS, cleansing solution), apply Bacitracin ointment (to help prevent minor skin injuries such as cuts, scrapes, and burns from becoming infected) mixed with hydrocortisone cream one percent (1%, medicated lotion, ointment or solution) and leave open to air.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and review on 1/23/2025 at 9:23 AM with the DSD, of Resident 23 care plan for alteration in physical function due to impaired mobility, revised on 3/9/2023 was reviewed. DSD stated the care plan indicated Resident 23 was totally dependent with bed mobility, transfer, locomotion, dressing, eating, personal hygiene, bathing. The care plan indicated Resident 23's selfcare and range of motion (ROM, the extent or limit to which a part of the body can be moved around a joint or a fixed point) had declined. The care plan indicated intervention to assist with ADL task which included: bed mobility, transfer locomotion, walking (if able) dressing, toilet use, personal hygiene and bathing.</p> <p>During a concurrent interview and review on 1/23/2025 at 9:23 AM with the DSD, Resident 23's care plan, initiated 1/28/2023 and revised 11/4/2024 was reviewed. The DSD stated the care plan indicated Resident 23 was at risk for skin discoloration and redness related to residents' behavior of combativeness and impulsiveness. The care plan indicated intervention to keep nails trimmed.</p> <p>During a concurrent interview and record review on 1/23/2025 at 9:23 AM with the DSD of Resident 23's care plan, initiated 12/30/2024 was reviewed. The DSD stated the care plan indicated scattered scratches at right lower leg.</p> <p>During concurrent observation and interview on 1/23/2024 at 12:24 PM with the Registered Nurse Supervisor (RNS), in Resident 23's room, Resident 23 was observed. RNS stated Resident 23's fingernails were jagged and not smooth. RNS stated Resident 23's right leg had multiple scattered scabs (a dry, rough protective crust that forms over a cut or wound during healing). RNS also stated fingernails of residents must be smooth all the time, without rough or sharp edges, especially for residents who are dependent to protect their skin.</p> <p>During a review of facility's policy and procedure (P&P) titled, Supporting Activities of Daily Living (ADL), revised 3/2018, the P&P indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>During a review of facility's P&P titled, Accommodation of Needs, revised 3/2022, the P&P indicated Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and /or achieving safe independent functioning, dignity and well- being. The P&P also indicated The resident's individual needs and preference are accommodated to the extent possible, except when the health and safety of the individual or other residents will be endangered.</p> <p>During a review of facility's P&P titled, Care Plans, Comprehensive and Person Centered, revised 3/2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial (relating to the interrelation of social factors and individual thought and behavior) and functional needs is developed and implemented for each resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for one (1) of three (3) sampled residents (Resident 11) who was assessed as at risk for falls by leaving Resident 11 unattended in Resident 11's high back wheelchair (a wheelchair that accommodates additional trunk support) on 11/20/2024.</p> <p>This deficient practice resulted in Resident 11 sustaining a fall in the resident's room on 11/20/2024 around 10:35 AM. Resident 11 fell forward while seated on the high back wheelchair. Resident 11 was found lying prone (a body position in which the person lies flat with the chest down and the backup) on left side facing towards the floor. Resident 11 sustained a left eyebrow laceration (a tear or cut in the skin) and was sent to the General Acute Care Hospital (GACH) on 11/20/2024 (time unknown) where Resident 11 was diagnosed with blunt head injury (an injury to the head caused by a forceful impact) and facial fractures (a partial or complete break in the bone).</p> <p>Findings:</p> <p>During a review of Resident 11's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), abnormal posture (involuntary and rigid body movements), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 11's Admission Fall Risk Assessment, dated 8/24/2024, the Admission Fall Risk Assessment indicated Resident 11 was a fall risk.</p> <p>During a review of Resident 11's Care Plan (CP), dated 8/24/2024, the care plan indicated Resident 11 has potential for falls related to antihypertensives (drug used to treat high blood pressure) medications, incontinence (a condition where a person experiences involuntary loss of urine or stool), dementia, and impaired mobility (the ability to move or be moved freely and easily). The care plan indicated a goal for the resident to not have major injuries from fall. The care plan interventions included were to administer medications as ordered, answer call light promptly, assist with transfers and mobility as needed (PRN), to not leave the resident unattended in shower room, and to keep the environment free from clutter.</p> <p>During a review of Resident 11's Physical Therapy (PT, treatment that helps improve how the body performs physical movements) evaluation and plan of treatment, dated 8/25/2024, the report indicated Resident 11's functional assessment was done and Resident 11 required total assistance from 1 staff with bed mobility (the ability to move from one position in bed to another), transfers, wheelchair mobility and wheelchair management (teaching a person how to use a wheelchair safely and independently).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 11's Occupational Therapy (OT, treatment that aims to improve the ability to perform daily activities) evaluation and Plan of treatment, dated 8/26/2024, the report indicated Physical/Cognitive/Psychosocial Performance for Resident 11 presents with impairments in balance and strength resulting in limitations and/or participation restrictions in the areas of mobility and self-care.</p> <p>During a review of Resident 11's History and Physical (H&P), dated 8/26/2024, the H&P indicated Resident 11 does not have the capacity to make decisions.</p> <p>During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 10/4/2024, the MDS indicated Resident 11's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). Resident 11 was dependent with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 11 was dependent with chair/bed to chair transfer (the ability to transfer to and from a bed to chair (or wheelchair). The MDS also indicated Resident 11 was dependent to wheel 50 feet with two turns (once seated in wheelchair, the ability to wheel at least 50 feet and make two turns. The MDS indicated Resident 11 has no history of falls.</p> <p>During a review of Resident 11's PT discharge summary, dated 10/4/2024, the report indicated discharge functional outcomes included the following:</p> <ul style="list-style-type: none"> o Static sitting (a position where you sit in a fixed posture for a prolonged period of time) = fair (able to maintain with upper extremities support) o Dynamic sitting (the practice of moving around while seated) = Poor + (sits unsupported with minimal assistance) o Static standing (positions where the body is held in a single alignment for a period of time) = poor (requires maximal assistance and upper extremities support) o Bed mobility = total assistance with 1 staff o Rolling = Total assistance with 1 staff o Transfers =Total assistance with 1 staff o Stand = Total assistance with 1 staff o Wheelchair mobility = Total assistance o Wheelchair management = Total assistance with 1 staff <p>During a review of Resident 11's CP, dated 11/16/2024, the CP indicated Resident 11 was dependent on staff for activities, cognitive stimulation, social interaction due to cognitive deficits, immobility, physical limitations. The CP interventions included for staff to provide Resident 11 assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) as required during the activity.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Broadway Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E. Broadway San Gabriel, CA 91776	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 11's Change of Condition (COC) evaluation, dated 11/20/2024, timed 11:01 AM, by Licensed Vocational Nurse 1 (LVN 1), the COC evaluation indicated on 11/20/2024 around 10:35 AM, Certified Nurse Assistant 5 (CNA 5) reported to LVN 1, CNA 5 put resident to wheelchair and turned around to get linen from bed. Resident moved quickly and fell forward laying prone on left facing towards the floor. The COC evaluation indicated LVN 1 immediately went to Resident 11's room and found Resident 11 on the floor bleeding from the left eyebrow. Resident 11's left eye was noted with discoloration and mild swelling, laceration on the left eyebrow which measured 0.5 centimeter (cm, unit of measurement) by 0.3 cm. The COC evaluation indicated Resident 11's primary care clinician (Doctor) was notified on 11/20/2024 at 10:38 AM, with an order to transfer Resident 11 to GACH via non-emergent ambulance for further evaluation.</p> <p>During a review of Resident 11's Progress Notes, dated 11/20/2024, timed 10:48 AM, the Progress Notes indicated the Director of Nursing (DON) indicated LVN 1 notified the DON regarding Resident 11's witnessed fall. The DON went to Resident 11's room and observed Resident 11 on the floor on a supine position (lying face upward) with left eyebrow laceration. The DON was unable to assess the left eye due to swelling. Resident 11 was observed with facial grimacing (a facial expression in which your mouth and face are twisted in a way that shows disgust, disapproval, or pain).</p> <p>During a review of Resident 11's GACH Emergency Department (ED) discharge instructions, dated 11/20/2024, the report indicated diagnoses included were blunt head injury and facial fractures.</p> <p>During a review of Resident 11's GACH radiology report (a medical document that provides a detailed interpretation of the results of an imaging test), the report indicated a computed tomography (CT, a medical imaging procedure) scan of the head was performed, completed on 11/20/2024 at 1:56 PM. The impression indicated left facial bone fracture and recommendation for CT facial bones.</p> <p>During a review of Resident 11's radiology report, the report indicated a CT facial was performed, completed on 11/20/2024 at 1:56 PM. The impression indicated the following:</p> <p>Acute displaced left anterior maxillary (the front teeth located in the upper jaw) wall fracture.</p> <p>Acute displaced left posterior lateral maxillary (the bones that form the upper part of the jaw) wall fracture.</p> <p>Acute displaced left zygomatic arch (a bar of bone that runs horizontally along the side of the head, positioned in front of the ear) fracture.</p> <p>Acute displaced left inferior orbital (the bottom of the left eye) wall fracture.</p> <p>During a review of Resident 11's Progress Notes, dated 11/20/2024, timed 5:49 PM, by Registered Nurse 2 (RN 2), the Progress Notes indicated Resident 11 was back to the facility from GACH ED after evaluation status post fall with facial injuries.</p> <p>During a review of Resident 11's Progress Notes, dated 11/21/2024, timed 6:14 AM, the Progress Notes indicated Resident 11 was on monitoring for status post fall (after a fall) with multiple facial fractures. It also indicated Resident 11 has left eyebrow laceration with steri-strips (thin, adhesive strips used to close small cuts).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/21/2025 at 10:50 AM, in the nursing station, Resident 11 was sitting in a Broda chair (wheelchair that provides comfort, support, and mobility throughout the day, with ability to tilt and recline), in a reclining position.</p> <p>During an interview on 1/23/2025 at 2:41 PM with LVN 1, LVN 1 stated that on 11/20/2024, morning shift (7 AM -3 PM), CNA 5 reported to her that Resident 11 had a fall. LVN 1 stated CNA 5 witnessed Resident 11 leaning forward and falling face down to the floor. LVN 1 stated CNA 5 informed her that CNA 5 transferred Resident 11 from the bed to the high back wheelchair. LVN 1 stated CNA 5 placed the wheelchair in front of the bed, turned around, walked to the side of the bed to get the linen and when he turned back to attend to Resident 11, CNA 5 witnessed Resident 11 falling. LVN 1 stated CNA 5 stated it happened quickly that CNA 5 did not have the chance to prevent Resident 11 from falling.</p> <p>During an interview on 1/23/2025 at 3:14 PM with RN 1, RN 1 stated Resident 11 is dependent from staff with ADL with transferring, eating, and shower. Resident 11 uses a high back wheelchair and if tilted, could prevent Resident 11 from leaning forward.</p> <p>During a telephone interview on 1/24/2025 at 10:03 AM with CNA 5, CNA 5 stated could not recall if Resident 11's high back wheelchair was reclined or not before the resident fell . CNA 5 stated he turned away from Resident 11 and walked a few steps to grab the linen on top of the barrel that was right outside Resident 11's room, and when he turned back to attend to Resident 11, Resident 11 was already falling. CNA 5 stated Resident 11 fell to the floor with his face down. CNA 5 stated that was all that he remembered.</p> <p>During an interview on 1/25/2025 at 11:02 AM with Occupational Therapist (professional who provides treatment that aims to improve individuals' ability to perform daily activities), Occupational Therapist stated Resident 11 has abnormal posture and required total assistance (a situation where a person is unable to complete an activity without full physical help) for wheelchair management.</p> <p>During an interview on 1/25/2025 at 11:19 AM with Physical Therapist Assistant (PTA), PTA stated Resident 11 was using a high back wheelchair before the fall on 11/20/2024. PTA stated high back wheelchair can be tilted and reclined for comfort, safety, and to help with Resident 11's postural problem. PTA added since Resident 11 has unpredictable movements, Resident 11 should not be left unattended. PTA stated there was a high chance for Resident 11 to fall if he was seated in a high back wheelchair that was not reclined or tilted.</p> <p>During a concurrent record review and interview on 1/24/2025 at 12:27 AM with the DON, Resident 11's medical records were reviewed. The DON stated he was notified by LVN 1 about the fall and went to Resident 11's room. The DON stated he observed Resident 11 on the floor, bleeding from his left eyebrow. The DON stated he does not recall Resident 11's high back wheelchair's set up. The DON stated, to prevent Resident 11 from falling, Resident 11 should not be left unattended. The DON stated Resident 11 has a care plan not to be left unattended in the shower, but it should be applied when Resident 11 is in the wheelchair as well.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, Managing Falls and Fall Risk, revised in March 2018, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Facility's P&P titled, Supporting Activities of Daily Living, revised in March 2018, the P&P indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living.</p> <p>During a review of Facility's P&P titled, Dementia, revised in November 2018, the P&P indicated direct care staff will support the resident in initiating and completing activities and tasks of daily living. Such as bathing dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care services for one of one sampled resident (Resident 9) by failing to ensure oxygen (a colorless, odorless gas necessary for most living organisms to breathe and function properly) was administered according to the physician's orders.</p> <p>This deficient practice placed Resident 19 at risk for experiencing complications such as respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing, rapid breathing, and low blood oxygen level) that can lead to serious illness and/or death.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/27/2024 and readmitted on [DATE] with diagnoses that included but not limited to acute on chronic combined systolic and diastolic congestive heart failure (a sudden worsening of a pre-existing chronic condition where the heart struggles to both pump blood effectively and fill properly due to stiffness, leading to fluid build-up and congestion in the body), acute respiratory failure with hypoxia (a condition where the lungs are unable to absorb enough oxygen into the blood), acute pulmonary edema (a life-threatening condition that occurs when fluid builds up in the lungs, making it difficult to breathe) and chronic pulmonary edema (a condition where fluid builds up in the lungs over time, making it difficult to breathe), pleural effusion (a condition where too much fluid builds up in the pleural cavity [the space between the lungs and chest wall]), and pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi).</p> <p>During a record review of Resident 9's History and Physical (H&P), dated 1/14/2025, the H&P indicated Resident 9 has the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2024, the MDS indicated Resident 9 required setup or clean-up assistance (Helper sets up or cleans up, resident completes activity) with eating, oral/toileting/personal hygiene, upper and lower body dressing and putting on/taking off footwear and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for shower or bathing self.</p> <p>During a review of Resident 9's Care Plan initiated on 8/13/2024 with revision date of 1/16/2025, the care plan indicated Resident is at risk for altered respiratory status difficulty breathing related to pulmonary edema, acute respiratory failure, acute CHF, and pleural effusion. Staff interventions included were to provide oxygen as ordered and to give medications as ordered by physician.</p> <p>During a review of Resident 9's Order Summary Report, dated 1/13/2025, the report indicated a Physicians order for Oxygen at 2 to 5 liters per minute via nasal cannula continuously for diagnosis of hypoxia (low levels of oxygen in your body tissues) related to CHF every shift.</p> <p>During an observation on 1/21/2025 at 9:24 AM, there was no oxygen sign outside Resident 9's room.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/21/25 at 9:37 AM in Resident 9's room, observed Certified Nurse Assistant 1 (CNA1) assisting Resident 9 from bedside commode (a portable toilet that can be used when someone is unable to walk to the bathroom) back to bed. Resident 9 was observed without an oxygen and was short of breath. CNA1 asked Resident 9 if Resident 9 wanted oxygen. Resident 9 responded yes. Observed CNA1 place the nasal cannula (a medical device that supplies oxygen to a patient through their nose) to the resident's nostrils and proceeded to turn the oxygen concentrator (a device that provides oxygen to people who have difficulty breathing) at 5 liters (a unit of measurement) per minute (min). Resident 9 whispered she was still short of breath even with the oxygen. CNA1 observed walking out of Resident 9's room and stated she would be back and would call the nurse.</p> <p>During a concurrent interview and record review with License Vocational Nurse 1 (LVN1) on 1/21/2025 at 9:45 AM, LVN1 stated Resident 9 does have an as needed (PRN) oxygen ordered. Observed LVN1 review Residents 9's medical information which indicated an order on 1/15/2025 for continuous oxygen at 2 to 5 liters/min via nasal cannula due to dx of hypoxia (low levels of oxygen in the body tissues) related to CHF every shift.</p> <p>During an interview 01/23/25 12:41 PM, the Director of Nursing (DON) stated oxygen is considered like regular medication order. The DON stated the resident was at risk of harm while complaining of shortness of breath because oxygen needed to be administered.</p> <p>During an interview with Director of Staff Development (DSD) on 1/24/2025 at 9:41 AM, DSD stated, Oxygen therapy is like a medicine that only licensed nurses can administer per Doctor's order.</p> <p>During a review of the facility Policy and Procedure (P&P) titled, Oxygen Administration, revised October 2010, the P&P indicated the purpose of the procedure is to provide guidelines for safe oxygen administration 2. Place an Oxygen in Use sign on the outside of the room entrance door. Close the door. 3. Place Oxygen in Use sign in a designated place on or over the resident's bed.</p> <p>During a review of the facility P&P titled, Preparation and General Guidelines effective date of October 2017 indicated, Medications are administered in accordance with written orders of the attending physician.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>46087</p> <p>Based on observation, interview, and record review, the facility failed to ensure staffing information (list of total number of staff and the actual hours worked by the staff) was posted and placed in a visible and prominent place on 1/21/2025 and 1/22/2025 in accordance with the facility policy.</p> <p>This deficient practice had the potential for residents and visitors not to be informed of the facility census and staffing.</p> <p>Findings:</p> <p>During an observation, on 1/21/2025 at 7:45 AM, no visible daily staffing information posting was found at the facility lobby.</p> <p>During a concurrent observation and interview on 1/22/2025 at 2:42 PM, in the lobby, with Registered Nurse (RN) 2, RN 2 stated the form titled Daily Direct Care Staffing (refers to the number of dedicated caregivers needed to provide immediate, hands-on personal care to individuals in a facility like a nursing) was posted on the wall behind the door which opens to the resident rooms. RN 2 stated the staffing posting with the information on the number of licensed nurses (Registered Nurse [RN] and Licensed Vocational Nurse [LVN]) and the number of unlicensed nursing personnel (Certified Nurse Assistants [CNA]) directly responsible for resident care has always been posted on the wall behind the door, which was not visible to residents, staff, and visitors.</p> <p>During a concurrent observation and interview on 1/22/2025 at 2:44 PM, in the lobby, with the Director of Nursing (DON), the DON stated that he did not know that the facility was posting the shift staffing information that consist of the census, the total number of RNs, LVNs, and CNAs working each shift behind the door. The DON added this posting should be easily seen and read by residents, visitors, and staff and that it was important to post the staffing information so residents and visitors would know that the facility is staffed with the required number of nurses to deliver care to the residents in accordance with the regulations.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, policy indicated facility will post on a daily basis for each shift the nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. It also indicated the number of licensed nurses (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on observation, interview and record review, the facility failed to accurately measure the salt content of food served for one of three sampled residents (Resident 17) who was on renal diet (a specialized dietary plan designed for individuals with kidney disease, and it aims to protect and improve the kidney function by limiting certain nutrients such as salt).</p> <p>This failure placed Resident 17 at risk for receiving more than the required amount of sodium (salt) which can lead to serious illness/ disease.</p> <p>Findings:</p> <p>During a review of Resident 17's admission record indicated, the resident was originally admitted at the facility on 5/21/2023 and was readmitted on [DATE]. with diagnoses that includes end stage renal disease (ESRD, is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and dependent on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly).</p> <p>During a review of the facility's menu titled Week 2 Regular Cambridge Broadway Cycle 1 2025 Winter indicated Breakfast: Wednesday 1/22/2025, juice, hot or cold cereal, scramble egg, bacon, toast/jelly, coffee, milk 2%, Margarine.</p> <p>During a concurrent observation and interview on 1/22/2025 at 6:55 AM, at the kitchen, observed [NAME] 1 pour a portion of a packet of Chicken Gravy Mix in a small pot with water. [NAME] 1 and did not use a measuring device to check the amount of the [NAME] Gravy before mixing it with the water. [NAME] 1 stated the gravy was for Resident 17 and that the resident always ask for extra gravy with his meals.</p> <p>During interview on 1/22/2025 at 8:05 AM with [NAME] 1, [NAME] 1 stated she cooks breakfast every Monday to Friday. [NAME] 1 also stated the Chicken Gravy Mix she prepared for Resident 17 was not measured, she eyeball it (approximating the amounts, instead of weighing them or using volume measurements). [NAME] 1 stated she was not supposed to eyeball the ingredients.</p> <p>During a test tray (exact duplicate of the food served) on 1/22/2025 at 8:10 AM with the Director of Nursing (DON), of Resident 17's sample tray. The DON tasted the gravy (same gravy served to Resident 17) and stated the gravy was salty. The DON also stated it was important to follow the exact measurement of recipe for all residents for therapeutic diet (a meal plan that controls the intake of certain foods or nutrients).</p> <p>During a concurrent interview and record review on 1/22/2025 at 1:57 PM with the Dietary Manager (DM) of the Chicken Gravy Mix, the chicken gravy mix indicated ingredient: brown gravy mix 10 ounce (oz, a unit of 4 serving 0.5 oz to hot water 140 degrees Fahrenheit (a scale for measuring temperature) 4oz. DM stated was [NAME] 1 not supposed to eyeball ingredients, everything needs to be measured when cooking to follow the dietary recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same concurrent interview and record review on 1/23/2025 at 12:54 PM with RNS 1, Resident 17's Order Summary Report dated 12/13/2024 and the facility's Policy and Procedure (P&P) titled Liberal Renal Diet for Selected Menu date revised 6/2019 were reviewed. RNS 1 stated the Order Summary Report indicated, please provide extra gravy RNS 1 also stated the facility's P&P titled Liberal Renal Diet for Selected Menu indicated the liberal renal diet for select menu follows the regular diet on select menu with the modifications such as eliminate salt packages.</p> <p>During a record review of facility's P&P titled Standardized Recipe revised date 2/4/2020 indicated each recipe shall be adjusted to be exact for every ingredient.</p> <p>a. Use weight for greatest accuracy</p> <p>b. Liquid may be measured</p> <p>c. Measuring small amount of seasoning spices and herbs is more accurate the weighing.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47362</p> <p>Based on observation, interview, and record review, the facility failed to ensure the food service area was maintained in a clean and sanitary manner and while providing proper food handling in accordance with the facility's policy and procedure by failing to:</p> <ol style="list-style-type: none"> 1. Ensure the juice machine did not contain gunk (an unpleasantly sticky or messy substance) inside the juice connector tube. 2. Ensure food container lids were closed. 3. Ensure food trays (meal trays) were in good repair and free from cracks and peels. <p>These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization .</p> <p>Findings:</p> <p>During observation on 1/21/2025 at 7:51 AM in the facility kitchen, the juice machine was observed with a box of orange juice connected to the machine. The machine was unclean and observed with dried coffee drippings. The connecting tube, that connected the juice machine to the juice box was observed with sticky brown and black gunk.</p> <p>During observation in the kitchen on 1/21/2025 at 7:52 AM, a container that contained ground ginger was observed. The ground ginger container had a blue lid that was not properly sealed the lid was open.</p> <p>During an observation in the kitchen on 1/22/2025 at 7:18 AM, coffee mugs were observed with stains.</p> <p>During an observation in the kitchen on 1/22/2025 at 7:26 AM, food trays were observed. All 17 food trays were observed with cracks, had chipping, and the laminate (a layer of plastic or some other protective material) was peeling off of the food trays.</p> <p>During a concurrent observation and interview on 1/22/2025 at 1:57 PM AM with Dietary Manager (DM), DM stated the orange juice box with the coffee and water drippings was observed. The DM stated connecting tube was dirty and had black sticky gunk on the outside of the juice connector tube. DM stated the juice connecting tube should be dirty and that the connecting tube should be replaced.</p> <p>During a follow up concurrent observation and interview on 1/22/2025 at 2 PM, with the DM, the DM stated the container of ground ginger and iodized salt was open. The DM stated all containers should be closed properly so dust, dirt or insects do not get into the container, since it might get mixed in with food.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Broadway Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E. Broadway San Gabriel, CA 91776	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the same concurrent observation and interview on 1/22/2025 at 2:02PM, with the DM, DM stated the coffee mugs had coffee stains, which were blackish brown in color.</p> <p>During the same concurrent observation and interview on 1/22/2025 at 2:03 PM, with the DM, the DM stated the food trays were cracked, chipped and were peeling, and that the meal trays were old. The edges of the trays were not smooth, and the laminate was peeling off. DM stated the cracked meal trays did not have smooth edges and was potentially unsafe for residents and staff. The DM stated when the kitchen was not clean, it can cause cross contamination and sickness to residents and staff, therefore the kitchen must always be clean.</p> <p>During interview on 1/22/2025 at 2:23 PM with the dietary assistant (DA 1), the DA stated food trays with cracked edges that were not smooth, could potentially harbor bacteria, and cause cross contamination. The DA stated all food containers must be closed properly since insects and tiny dust can get into opened containers of food, causing cross contamination and can potentially cause DA 1 also stated can cause stomachache, diarrhea.</p> <p>During record review of facility's Policies and Procedures (P&P) titled Sanitation date revised 11/2022 indicated the food service area is maintained in clean and sanitary manner. All kitchen areas and dining areas are kept clean, free from garbage and debris and protected from rodents and insects. All utensils, shelves and equipment are kept clean, maintained in good repair and free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair.</p> <p>During record review of facility's P&P titled Food Receiving and storage date revised 11/2022 indicated Food shall be received and stored in a manner that complies with safe food handling and practices.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to follow its infection control policy for one (1) of 18 sampled residents (Resident 158) by failing to ensure enhanced barrier precaution (EBP, an infection control practice that involves wearing isolation gowns and gloves during high-contact activities with residents with wounds in nursing homes) was implemented to Resident 158 who has a wound.</p> <p>This deficient practice had the potential to result in Resident 158 developing an infection and spread of infection among staff and residents.</p> <p>Findings:</p> <p>During a review of Resident 158's Admission record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 158 was originally admitted to the facility on [DATE]. Resident 158's diagnoses included stage two (2) pressure ulcer of sacral region (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), urinary tract infection (UTI- an infection in the bladder/urinary tract) and sepsis (a life-threatening blood infection).</p> <p>During a review of Resident 158's Admission Data Tool (assessment tool used upon admission), dated 1/1/2025, indicated Resident 158 have pressure ulcer. It indicated EBP is not warranted (based on a patient's current condition, the extra protective measures of EBP are not necessary). It also indicated Resident 158 required one-person physical assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed), and Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) transferring.</p> <p>During a review of Resident 158's IDT wound management assessment, dated 1/2/2025, indicated Resident 158 was a newly admit resident, with skin breakdown.</p> <p>During a review of Resident 158's interdisciplinary team (IDT, a group of professionals who work together to assess and care for residents) wound management assessment, dated 1/20/2025, indicated Resident 158 stage 2 pressure ulcer regressed to stage three (3).</p> <p>During an observation on 1/21/2025 at 7:59 AM, Resident 158 is laying in bed, no EBP signage posted before entering the resident's room or posted inside the resident's room and no personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart outside Resident 158's room.</p> <p>During a concurrent observation and interview on 1/23/2025 at 7:40 AM with Infection Preventionist Nurse (IPN), outside Resident 158's room, EBP signage and PPE cart was not observed. IPN stated Resident 158 does not have to be on EBP because Resident 158's sacral wound has no drainage.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review 1/23/2025 at 10:50 AM with Treatment Nurse (TN), Resident 158's order summary report dated 1/23/2025 was reviewed. The order summary report did not indicate EBP precautions. TN stated Resident 158 was admitted on [DATE] with open wounds, and EBP was not ordered and implemented because Resident 158's wounds have no drainage. TN stated she did not and should have worn isolation gown during wound care treatment to Resident 158 since admission on 1/2/2025. TN also stated Resident 158's admission data tool dated 1/1/2025 was completed incorrectly since it indicated EBP was not warranted, but Resident 158 was admitted with wound, Resident 158 should have been placed on EBP since admission.</p> <p>During an interview with the Director of Nursing (DON) on 1/23/2025 at 12:21 PM, the DON stated, we all thought EBP is only for residents with moderate to heavy wound drainage. The DON stated EBP should have been ordered as soon as Resident 158 was admitted at the facility and added in Resident 158's care plan. The DON stated there was no EBP signage outside Resident 158's room to alert staff and visitors to wear appropriate PPE while rendering close contact care like wound care, bed bath and diaper change to Resident 158.</p> <p>During a record review of Facility's Policy and Procedure titled Enhanced Barrier Precautions, dated April 2024, indicated examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:</p> <ul style="list-style-type: none"> a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. wound care (any skin opening requiring a dressing). <p>It also indicated EBPs are indicated for residents with wounds. EBPs remain in place for the duration of the resident's stay or until resolution of the wound. The P&P indicated signs are posted on the resident's door or wall outside the resident room indicating the type of precautions and PPE required. The P&P also indicated, PPE supplies will be made available near or outside of the resident rooms, placement is at the discretion of the facility.</p>		

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<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview and record review, the facility failed to ensure one (1) of 24 rooms (room [ROOM NUMBER]) accommodated no more than four residents in each room. Room O has five (5) residents and five (5) beds.</p> <p>This deficient practice has the potential for the resident's care and services to not be adequately accommodated, have an adverse effect on the residents' safety, affect provision of care and services, and place residents at risk for lack of privacy.</p> <p>Findings:</p> <p>During an observation of Room O on 1/24/25 from 8:50 AM, observed Room O with five beds in a room. In room [ROOM NUMBER], all five beds were observed to be occupied.</p> <p>During a review of the room waiver, dated 01/16/24, the room waiver indicated the following:</p> <p>Room #Beds square foot (sq. ft, unit of measurement)</p> <p>0 5 511.60</p> <p>During a concurrent review of the facility's client accommodation analysis and interview with the Administrator (Admin) on 1/24/25 at 10 AM, the Admin verified the client accommodation analysis indicated the facility has 24 resident's rooms and Room O has 5 beds and 5 residents. The Admin stated he will continue to request for room waiver because it did not affect the health and safety of the residents. The Admin stated there was enough space for the staff to provide care to the residents.</p> <p>During a review of the facility's room waiver letter, dated 1/21/25, the waiver indicated a request for the continued waiver for square footage per resident, in the condition that room assignments are reviewed during the admission process and checked frequently for appropriateness. The waiver indicated ample space is provided for resident care and mobility, allowing the facility to meet residents needs without adversely affecting resident's health and welfare. Room rounds are also conducted to ensure there are no unnecessary items or equipment maintained in stored in the rooms that prevent access.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>45523</p> <p>Based on observation, interview and record review, the facility failed to provide the minimum of 80 square feet (sq. ft., unit of measurement) per resident in multiple resident bedrooms for 14 of 24 residents' rooms in the facility, unless granted a room waiver by the Centers for Medicare and Medicaid services (CMS).</p> <p>This deficient practice had the potential to result to inadequate space for resident care, mobility, and privacy of the residents.</p> <p>Findings:</p> <p>During a tour of the facility on 1/24/25 at 10:00 AM, 14 of 24 residents' rooms did not meet the minimum 80 sq. ft. per resident in multiple resident bedrooms. These were rooms A, B, C, D, E, F, G, H, I, J, K, L, M, and N. The residents did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. Residents that were wheelchair bound were able to move in the room without difficulty.</p> <p>During a concurrent review of the facility's client accommodation analysis and interview with the Administrator (Admin) on 1/24/25 at 10:20 AM, the Admin stated the facility have 24 resident rooms. The Admin stated 14 rooms do not met the 80 square feet per resident in multiple resident bedrooms. The Admin stated he will continue to request for room waiver because it did not affect the health and safety of the residents. The Admin stated there was enough space for the staff to provide care to the residents.</p> <p>During a review of the facility's Client Accommodation Analysis form, dated 1/21/25, the client accommodation analysis indicated the actual square footage of Resident rooms A, B, C, D, E, F, G, H, I, J, K, L, M, and N not meeting the required room size as followed:</p> <p>Room #Beds Sq.Ft. Sq.Ft. per Bed</p> <p>A 2 156.51 78.25</p> <p>B 2 159.33 79.66</p> <p>C 2 156.51 78.25</p> <p>D 2 159.04 79.52</p> <p>E 2 155.40 77.70</p> <p>F 2 155.40 77.70</p> <p>G 2 155.40 77.70</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>H 2 157.62 78.81</p> <p>I 2 155.40 77.70</p> <p>J 2 158.20 79.10</p> <p>K 2 155.40 77.70</p> <p>L 2 155.40 77.70</p> <p>M 2 159.33 79.66</p> <p>N 2 159.33 79.66</p> <p>During a review of the facility's room waiver letter, dated 1/21/25, the waiver indicated a request for the continued waiver for square footage per resident, in the condition that room assignments are reviewed during the admission process and checked frequently for appropriateness. The waiver indicated ample space was provided for resident care and mobility, allowing the facility to meet residents needs without adversely affecting resident's health and welfare. Room rounds were also conducted to ensure there were no unnecessary items or equipment maintained in stored in the rooms that prevent access.</p> <p>During the recertification survey from 1/21/25 to 1/24/25, Rooms A, B, C, D, E, F, G, H, I, J, K, L, M, and N, had adequate ventilation and lighting. The residents in the rooms had bathroom and toilet facilities. The residents had privacy curtains around their beds, and which assured privacy. There was adequate space for getting in and out of the wheelchairs and residents were afforded sufficient freedom of movement in the rooms.</p>		