STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not implement water sample testing (to collect and deliver for analysis a sample of water representative of the bulk of water being examined) to validate the facility's water management program control measures (actions that can be taken to reduce the potential of exposure to a hazard) on an ongoing basis to ensure the facility's water was free of waterborne (carried or transmitted by water and especially by drinking water) pathogens (any organism that can cause disease) such as legionella (a bacterium which cases legionnaires' disease [a severe form of pneumonia - lung inflammation usually caused by infection]). This failure had the potential to place the residents in the facility at risk for developing severe respiratory infection (pneumonia), which could result in residents' hospitalization, complications, and death.Findings: During an interview on 2/5/2026 at 1:41 PM with Infection Preventionist (IP), IP stated the facility does not do any type of water testing annually to validate their controls since it is not a requirement from the Centers for Medicare and Medicaid Services (CMS; a U.S. federal agency that sets the quality standards for nursing homes and aims to improve healthcare access and efficiency). IP stated she knows that there was an initial test done a long time ago when the facility had a legionella outbreak but have since incorporated a ultraviolet (UV; a type of electromagnetic [relating to or caused by magnetism (the power of an object to attract other object to it) that is produced by electricity] radiation [energy that moves from one place to another in a form that can be described as waves or particles] that has shorter wavelengths [the physical distance between two identical points] than visible light) light water treatment system (a chemical free method that uses UV light to disinfect water by destroying up to 99.99% of bacteria, viruses, and parasites) and have not done any type of water testing since it was incorporated.During an interview on 2/5/2026 at 2:37 PM with IP, IP stated the only validation they would do for their controls would be if one of the control measures was not met or not effective and stated their controls for their water management program have been working since they had not had any residents with legionella.During a concurrent interview and record review on 2/5/2026 at 2:59 PM with IP, the Centers for Disease Control's (CDC) toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/24/2021 was reviewed. The CDC toolkit indicated, Now that you have a water management program, you need to be sure that it is effective. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called ?validation.' Environmental testing for Legionella is useful to validate the effectiveness of control measures. The program team should determine if environmental testing for Legionella should be performed and, if so, how test results will be used to validate the program. Factors that might make testing for Legionella more important include: Being a healthcare facility that provides inpatient services to people who are at increased risk for Legionnaires' disease. IP stated they had only had testing done initially in 2018 and did not do any water testing afterwards. IP further stated the importance of validating controls on an ongoing basis is to prevent legionella from happening in the facility. During an interview on 2/6/2026 at 11:10 AM with Maintenance Supervisor (MS), MS stated in (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2018 the facility had a case of legionella, and they had done water testing after incorporating the UV light water treatment system. MS stated they had not done any water testing since 2018 and do not do any validation of their controls. MS further stated it is important to validate the controls of their water management program to prevent a resident from waterborne pathogens. During a review of the facility's policy and procedure (P&P) titled Legionella Water Management Program, revised September 2022, the P&P indicated the facility is committed to the prevention, detection and control of water-borne contaminants, including legionella. The P&P also indicated, The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a legionella water management program. The P&P further indicated the water management program will include the following elements:Specific measures used to control the introduction and/or spread of legionella (e.g. [for example] temperature, disinfectants)A system to monitor control limits and the effectiveness of control measures. During a review of the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Survey and Certification Group letter titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) dated 6/2/2017, indicated, Surveyors will review policies and procedures and reports documenting water management implementation results to verify that facilities:Implement a water management program that considers the ASHRAE industry standard and the Centers for Disease Control (CDC) toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing for pathogens.Specify testing protocols and acceptable ranges for control measures, and document the result of testing and corrective actions taken when control limits are not maintained. A review of ASHRAE Addendum to ASHRAE Standard [PHONE NUMBER] (defines types of buildings and devices that need a water management program) titled, Legionellosis: Risk Management for Building Water Systems, dated 6/23/2018, indicated the Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program is being implemented as designed. The resulting process is verification. The Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program, when implemented as designed, controls the hazardous conditions throughout the building water systems. The resulting process is validation. The Program Team shall determine whether testing for Legionella shall be performed and if so, how test results will be used to validate the Program. If the Program Team determines that testing is to be performed, the testing approach, including sampling frequency, number of samples, locations, sampling methods, and test methods, shall be specified and documented. The Program Team shall consider include the following as part of the determination of whether to test for Legionella:b. A healthcare facility provides in-patient services to at-risk or immuno-compromised population.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper food handling practices and maintain the food service area in a clean and sanitary manner in accordance with the facility's policies and procedures (P&P) by failing to ensure:The can opener was not chipped and peeling.The garlic powder container lid was closed.Six (6) of 6 rice soup bowls were measured during lunch preparation on 2/5/2026.These deficient practices have the potential to expose residents to pathogens (germs), placing them at risk for developing foodborne illness (food poisoning), which may cause symptoms such as upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever which could lead to serious medical complications and hospitalization, and not measuring the food had the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss for 6 of 6 residents who were served the rice soup.Findings:During an observation in the facility's kitchen on 2/4/2026 at 9:04 AM, the can opener was observed to be chipped and peeling. During an observation in the facility kitchen on 2/4/2026 at 9:05 AM, the plastic lid of the garlic powder observed on the stainless-steel wall shelf was not closed. During a concurrent observation in the facility kitchen and interview with the Dietary Supervisor (DS 1) on 2/4/2026 at 9:07 AM, the DS stated the can opener was observed to be chipped and peeling. During a concurrent observation in the facility kitchen and interview with DS 1 on 2/4/2026 at 9:08 AM, DS 1 stated the plastic lid of the garlic powder observed on the stainless-steel wall shelf was not closed. During tray line (a centralized, assembly-line food service system where workers stand at stations adding specific items [starters, cold foods, hot entrees, checkers] to patient trays as they move along a conveyor belt or line) observation in the facility kitchen on 2/5/2026 at 12:09 PM, observed Dietary Aide (DA 1) pour pureed (food that has been blended or processed into a smooth, uniform consistency without lumps, making it easy to swallow) rice soup to 6 bowls without measuring. During an interview on 2/25/2026 at 2:25 PM with DA 1, DA 1 stated that she poured the pureed rice soup from the stainless-steel container into 6 bowls for 6 residents who do not like beef, without measuring the portions. DA 1 further stated she should have used a 6-ounce (oz, a unit of weight measurement equal to one-sixteenth of a pound) ladle (large, deep-bowled, long-handled spoon primarily used for scooping and serving liquids like soups, stews, and sauces, as well as portioning) for proper portion control. During an interview on 2/5/2026 at 2:52 PM with [NAME] 1, [NAME] 1 stated the can opener was old, chipped, and peeling. [NAME] 1 stated the garlic powder container lid was open. [NAME] 1 also stated the can opener was not supposed to be chipped and peeling, and that all food containers were supposed to be properly closed all the time to prevent food contamination, which could possibly cause diarrhea, stomachache and vomiting. During an interview on 2/5/2026 at 2:56 PM with [NAME] 1, [NAME] 1 stated food was supposed to be measured at all times to ensure the residents received the right amount of nutrition they need. During an interview on 2/5/2026 at 3 PM with DS 1, DS 1 also stated that all containers are supposed to be closed properly to prevent food contamination and maintain the quality of food, and all equipment was supposed to be in good condition. During an interview on 2/5/2026 at 3:02 PM with DS 1, DS 1 stated the food served to residents was always supposed to be measured to ensure the right amount of nutrition and to maintain portion control. During a record review of the facility's Policy and Procedures (P&P) titled, Food Receiving and Storage, revised 11/2022, the P&P indicated food shall be received and stored in a manner that complies with safe food handling practices. The dry food and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. During a record review of the facility's P&P titled, Sanitation, revised 11/2022, the P&P indicated that all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracked and chipped areas that may affect their use or proper cleaning. During a record review of the facility's P&P titled, Kitchen Weights and Measures, revised 4/2007, the P&P indicated the food services staff will be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trained in proper use of cooking and serving measurements to maintain portion control. The P&P indicated serving utensils used will be consistent with choice of metric (system of measurement) or U.S. measure (United States customary units form a system of measurement units) used. Staff will be trained in the appropriate measurement and type of serving utensil to use for each food. The P&P also indicated the food service supervisor will ensure cooks prepare the appropriate amount of food for the number of servings required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Answering the Call Light (one of the major communication technologies that link nursing home staff to the needs of residents) for three (3) of four (4) sampled residents (Residents 7, 18 and 19) reviewed for environment by:1. and 2. Ensuring Residents 7 and 19 had their call light within reach.3. Ensuring Resident 18 had a working and functional call light. These failures had the potential to put Residents 7, 18 and 19 at risk of experiencing a delay in receiving assistance from facility staff which could lead to a fall or accident.Finding:1. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), dementia (progressive brain disorder that slowly destroys memory and thinking skills), muscle weakness. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 7's cognitive skills (processes of thinking and reasoning) for daily decision making were severely impaired (never/rarely made decisions). The MDS also indicated Resident 7 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of two [2] or more helpers is required for the resident to complete the activity) on personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands), roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed) and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). During a review of Resident 7's Care Plan, revised 12/31/2025, the Care Plan indicated Resident 7's has a communication problem related to language barrier. The resident is nonverbal and has impaired vision. The care plan indicated under interventions to ensure the call light should be within reach and that adequate low glare light should be provided. During observation on 2/4/2026 at 3:06 PM in Resident 7's room, Resident 7's call light was on the right side of the bed, hanging facing towards the floor and not within Resident 7's reach. During concurrent observation and interview on 2/4/2026 at 3:08 PM in Resident 7's room with the Certified Nursing Assistant (CNA 5), CNA 5 stated Resident 7's call light was at the right side of the bed, hanging facing towards the floor and out of the resident's reach. During an interview on 2/6/2026 at 11:24 AM with the License Vocational Nurse (LVN 2), LVN 2 stated the residents' call light should be within resident's reach all the time. LVN 2 also stated, if it is not within the resident's reach, the resident cannot call or ask for help from the staff. During an interview on 2/6/2026 at 2:09 PM with LVN 3, LVN 3 stated the call light should be within residents' reach because it is the resident's mode of communication to the facility staff when the resident needs assistance. During a record review of the facility's Policy and Procedures (P&P) titled Call System, Residents undated, was reviewed. The P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. 2. During a review of Resident 19's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of hypotension (low blood pressure) and dementia. During a review of Resident 19'S MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated Resident 19 was dependent with changing from sitting- to-standing, rolling left and right in bed, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 19 needed substantial/maximal assistance (helper does more than half the effort) with upper body dressing (the ability to dress and undress above the waist), personal hygiene and eating.During a review of Resident 19's Care Plan dated 1/2/2026, Resident 19's Care Plan indicated Resident 19 had a communication problem related to the resident's hearing deficit and indicated an intervention to ensure and provide a safe environment with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the call light being in reach. During a review of Resident 19's Care Plan dated 1/2/2026, Resident 19's Care Plan indicated Resident 19 was at risk for falls with injury related to limited mobility and indicated an intervention to be sure the resident's call light is within reach and to encourage the resident to use it. During an observation on 2/4/2026 at 10:22 AM in Resident 19's room, Resident 19 was observed asleep in bed with her call light observed hanging off the right side of her bed behind the bed's upper right quarter side rail and not withing the resident's reach.During a concurrent observation and interview on 2/4/2026 at 10:46 AM with Resident 19 in her room, Resident 19's call light was observed hanging off the right side of the resident's bed behind the bed's upper right quarter side rail. Resident 19 stated she could not find or reach her call light. Resident 19 also stated, Is it here? They always hide it from me. During a concurrent observation and interview on 2/4/2026 at 10:48 AM with CNA 2 in Resident 19's room, Resident 19's call light was observed hanging off the right side of her bed behind the bed's upper right quarter side rail. CNA 2 stated Resident 19's call light was hanging off the right side of her bed and out of reach.During an interview on 2/6/2026 at 9:32 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated a call light is for the resident's to use whenever they need help or assistance from the staff and should be within the resident's reach. RNS 1 stated if a call light is out of the resident's reach, there is a risk for the resident not to be able to call for assistance and could possibly result in them (resident/s) yelling out for help or getting up out of bed without assistance. 3. During a review of Resident 18's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of dementia and hypertensive chronic kidney disease (a condition where long-term, high blood pressure damages the blood vessels in the kidneys reducing their ability to filter waste and excess fluid from the body) . During a review of Resident 18'S MDS, dated [DATE], the MDS indicated the resident had severe impairment with cognitive skills for daily decision making. The MDS also indicated, Resident 18 was dependent with chair/bed-to-chair transfers, going from sitting to standing, rolling left and right in bed, putting on/taking off footwear and lower body dressing. In addition, the MDS indicated Resident 18 needed substantial/maximal assistance with upper body dressing, needed partial/moderate assistance (helper does less than half the effort) with personal hygiene and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. During a review of Resident 18's Care Plan dated 1/19/2026, Resident 18's Care Plan indicated Resident 18 was at risk for falls with injury related to limited mobility and indicated an intervention to be sure the resident's call light is within reach and encourage the resident to use it. During an observation on 2/4/2026 at 10:05 AM inside Resident 18's room, Resident 18's call light was observed to not work and light up to alert the staff assistance is needed when Resident 18's call light button was pressed. During a concurrent observation and interview on 2/4/2026 at 10:09 AM with CNA 1, Resident 18's call light was observed to not turn on when Resident 18's call light button was pressed. CNA 1 stated the call light is not working.During an interview on 2/6/2026 at 4:13 PM with the Director of Nursing (DON), the DON stated the purpose of the call light is for residents to use them to gain the attention of the staff when the residents need something. The DON stated the call lights need to be within the resident's reach and functioning at all times so that the residents can use the call light to call for help. The DON also stated, if the resident's call light is out of reach or not working, the resident would not be able to call for help, and the residents might yell for help and experience a delay in care. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised September 2022, the P&P indicated the purpose of the procedure is to ensure timely responses to the resident's requests and needs. The P&P further indicated to be sure the call light is plugged in and functioning at all times and to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote respect and dignity for two (2) of 21 sampled resident (Residents 7 and 12) reviewed for dignity when the facility did not ensure:1. Resident 7's indwelling catheter (tube that drains urine from the bladder into a drainage bag) was kept in a dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so urine is not visible).2. Resident 12's soiled bib was not kept on after eating breakfast on 2/6/2026.This deficient practice had the potential to negatively impact Resident 7 and 2's self-esteem and psychosocial well-being (state of mental, emotional, and social health of an individual).Findings: 1.During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE]. Resident 7's diagnoses included hypertension (high blood pressure), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and muscle weakness. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 7's cognitive skills (processes of thinking and reasoning) for daily decision making were severely impaired (never/rarely made decisions). The MDS also indicated Resident 7 was dependent on personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands), Roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed). Lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). The MDS also indicated that Resident 7 had an indwelling catheter. During a review of Resident 7's Order Summary Report, dated 2/5/2026, the Order Summary Report indicated a physician's order dated 1/31/2026 for Foley catheter (FC, a common type of indwelling catheter) French 16 (size) with 10 milliliter (ml, unit of fluid volume, used to inflate the retention balloon of a indwelling catheter to hold it in place inside the bladder) to bedside drainage (BSD, bag attached to the indwelling urinary catheter to collect the urine). During an observation in Resident 7's room on 2/4/2026 at 10:57 AM, Resident 7 was sitting on a Broda chair (specialized wheelchair designed to provide advanced comfort, support, and safety for individuals with complex mobility or positioning needs). Resident 7's FC drainage bag was observed with approximately 10 ml of yellowish colored urine. Resident 7's FC drainage bag was observed without a dignity bag. During a concurrent observation and interview on 2/4/2026 at 11AM in Resident 7's room, with the licensed vocational nurse 2 (LVN 2), LVN 2 stated Resident 7's Foley catheter drainage bag was not covered. During an interview on 2/6/2026 at 11:52 AM with LVN 2, LVN 2 stated the residents' drainage bag needs to have a dignity bag to provide dignity and privacy to prevent residents from emotional distress or embarrassment. During an interview on 2/6/2026 at 2:07 PM with LVN 3, LVN 3 stated the resident's drainage bag needs to have a dignity bag to provide dignity and privacy. LVN 3 stated if the drainage bag is not covered, the resident could feel embarrassed or exposed when other residents or visitors see the urine. 2.During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was initially admitted to the facility on [DATE]. Resident 12's diagnoses included hypertension (high blood pressure), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12's cognitive skills for daily decision making were severely impaired. The MDS also indicated Resident 12 required partial/moderate assistance (helper does less than half the effort. helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. The MDS indicated Resident 12 was dependent on personal hygiene and lying sitting on side of bed. During a review of Resident 12's Care Plan, initiated 3/9/2021, revised 2/4/2026, the Care Plan indicated Alteration in physical functioning (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to decreased mobility and activity and incontinence. The care plan also indicated staff intervention included was to assist with all activities on daily living (ADL, activities related to personal care which include bathing/showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) task such as bed mobility, transfer, locomotion, walking dressing, toilet use, personal hygiene and bathing.) During a concurrent observation and interview on 2/6/2026 at 9:02 AM in Resident 12's room with certified nursing assistant (CNA 6), CNA 6 stated Resident 12 was lying on bed with a soiled bib (garment hanging from the neck on the chest to protect clothing from accidentally spilled food) observed with food from breakfast. CNA 6 stated that right after eating, Resident 12's bib should have been removed, and the resident should have been cleaned. During a concurrent observation and interview on 2/6/2026 at 9:07 AM at Resident 12's room with the LVN3, LVN 3 stated Resident 12 was observed wearing a soiled bib with food from breakfast. LVN 3 stated this was not acceptable and that residents need to be cleaned after each meal to maintain dignity and respect. During a record review of the facility's Policy and Procedure (P&P) titled Dignity, revised date 11/2021, the P&P indicated each resident shall be cared for in a manner that promotes and enhanced his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. The P&P indicated residents are treated with dignity and respect at all times. The P&P also indicated the facility provides residents with a dignified dining experience.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 39) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to ensure Resident 39's Ativan (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities) as needed (PRN) order had a documented rationale for extended use, beyond 14 days, in accordance with the facility's policy and procedures (P&P). This deficient practice had the potential to place Resident 39 at risk for significant adverse consequences (serious negative outcomes resulting from an event, action, or situation) from the use of unnecessary psychotropic drug, which could result in impairment or decline in the residents' mental, physical condition, functional, and psychosocial statusFindings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 39 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 39 has symptoms of feeling down, depressed and hopeless. The MDS indicated Resident 39 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, and upper body dressing. The MDS indicated Resident 39 was dependent (helper does all of the effort) with shower, lower body dressing and putting on/off footwear. The MDS indicated Resident 39 was taking antipsychotic medications (primarily used to treat psychosis [a condition that affects how a person perceives reality]). During a review of Resident 39's Order Summary Report, dated 2/5/2026, the Order Summary Report indicated Ativan tablet one (1) milligram (mg, unit of measurement), give 1 tablet by mouth, every four (4) hours as needed for anxiety for 90 days manifested by verbalization of feeling anxious, panic attack resulting to shortness of breath, ordered on 1/30/2026, with end date of 4/30/2026. During a concurrent record review and interview on 2/6/2026 at 11:27 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 39's Ativan order was reviewed. LVN 3 verified Resident 39 has an order of Ativan as needed for anxiety ordered on 1/30/2026, for 90 days. LVN 3 stated that on 1/30/2026, Resident 39 was admitted to hospice care and the Ativan as needed order was part of the hospice orders. LVN 3 stated there was no documented reason in Resident 39's medical records why Resident 39 can be on as needed Ativan order for 90 days instead of limiting to 14 days. LVN 3 stated Resident 39's Ativan as needed order should have been limited to 14 days. LVN 3 added that a reevaluation to include a rationale will be needed to continue for Resident 39 to receive Ativan beyond 14 days as indicated on the facility policy. During an interview on 2/6/2026 at 3:09 PM with the MDS Nurse (MDSN), the MDSN stated as needed Ativan order should be limited to 14 days to minimize the use of psychotropic medication. The MDSN stated that when it comes to psychotropic orders, licensed nurses need to inform the resident's physician or Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) of the resident's status and behavior. The MDSN stated Psychiatrist reevaluation for the use of as needed Ativan every 14 days was important to check the effectiveness of the medication, and the need for order adjustment. The MDSN stated the psychiatrist needs to give the order for adjustments and duration. The MDSN added that when Psychiatrist decides for as needed psychotropic medication to extend to 90 days, resident evaluation and rationale (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation should be done prior to putting an order. During an interview on 2/6/2026 at 4:55 PM with the Director of Nursing (DON), the DON stated as needed Ativan order can be ordered for 90 days if there is documentation from Psychiatrist as to why Ativan needs to be extended for more than 14 days. The DON stated that there was no Psychiatrist documentation prior to Resident 39's Ativan as needed order for 90 days on 1/30/2026. During a review of Facility's P&P titled, Psychotropic Medication Use, dated July 2022, the P&P indicated as needed (PRN) orders for psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) to address the use of hearing aid for one (1) of 1 sampled residents (Resident 19) reviewed for hearing. This failure had the potential to result in Resident 19 not receiving the proper care and interventions to aid in the resident's hearing.During a review of Resident 19's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Meniere's disease (a chronic inner ear disorder causing unpredictable episodes of severe vertigo [spinning], fluctuating hearing loss, tinnitus [ringing/roaring], and a feeling of fullness or pressure in the ear). During a review of Resident 19'S Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2026, the MDS indicated the resident was severely impaired (never/rarely made decisions) with cognitive (ability to think, remember, and reason) skills for daily decision making and use of hearing aids. The MDS indicated Resident 19 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of two [2] or more helpers is required for the resident to complete the activity) with going from sitting to standing, rolling left and right in bed, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). The MDS also indicated Resident 19 needed substantial/maximal assistance (helper does more than half the effort) with upper body dressing (the ability to dress and undress above the waist), personal hygiene and eating.During an interview on 2/4/2026 at 10:46 AM with Resident 19, Resident 19 stated she is hard of hearing and needed hearing aids.During a concurrent interview and record review on 2/6/2026 at 1:47 PM with Infection Preventionist (IP), Resident 19's Clothing and Possessions inventory list dated 1/2/2026 and electronic medical record (EMR; a digital version of a resident's paper chart) dated 1/1/2026 to 2/6/2026 were reviewed. Resident 19's Clothing and Possessions inventory list indicated Resident 19 had two (2) hearing aids and Resident 19's EMR indicated a care plan for Resident 19's risk for communication deficit related to the resident's hearing deficit on 1/11/2026 but the care plan did not address Resident 19's need and use of hearing aids. IP stated Resident 19 did have 2 hearing aids, and no care plan was created to address Resident 19's use of hearing aids. IP further stated a care plan specifically for Resident 19's use of hearing aids should have been created so that staff know Resident 19 is hard of hearing and needs an assistive device to help her hear. During an interview on 2/6/2026 at 2:59 PM with Minimum Data Set Nurse (MDSN), MDSN stated Resident 19 having hard of hearing and the use of hearing aids should have been care planned so that all staff would know Resident 19 needs hearing aids to aid in the resident's communication. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P also indicated the comprehensive, person-centered care plan: describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with the professional standards practice (authorized, authoritative guidelines established by professional bodies to define the expected behaviors, skills, ethics, and knowledge required for competent practice) for two (2) of 22 sampled residents (Resident 7 and 34) by:Failing to ensure Resident 7 was provided with a safe and appropriately sized broda chair (a special medical reclining wheelchair used in nursing homes and hospitals for residents who need extra support and positioning). On 2/4/2026, Resident 7 was observed seated in a broda chair that was too short, with both lower legs (from foot to below the resident's knee) hanging and with no support.Failing to ensure Resident 34's bedside rails (metal or plastic barriers attached to the sides of a bed frame) order was followed in accordance with the doctor's order. These deficient practices placed the residents at risk of discomfort, poor circulation, and inadequate lower extremity support.Findings: 1.During a record review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE]. Resident 7's diagnoses included hypertension (high blood pressure), dementia (progressive brain disorder that slowly destroys memory and thinking skills), pressure ulcer (an injury that breaks down the skin and underlying tissue) of sacral region (bone at the end of the spine) stage 4 (pressure injury is very deep, reaching into muscle and bone and causing extensive damage). During a record review of Resident 7's Physical Therapy Evaluation and Plan of Treatment start of care dated 1/6/2026, it indicated wheelchair assessment to include sitting up in broda chair to encourage socialization and relieve pressure. During a record review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 7's cognitive skills (processes of thinking and reasoning) for daily decision making were severely impaired (never/rarely made decisions). The MDS also indicated Resident 7 was dependent on personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands), roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed) and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). During a record review of Resident 7's Braden Scale (an assessment tool used for predicting the risk for developing pressure sores (pressure ulcer) dated 1/12/2026, it indicated Resident 7 is at high risk for developing pressure ulcer. During a record review of Resident 7's Care Plan for resident is at risk for pressure sore or potential for pressure ulcer development related to disease process, immobility, incontinence, admitted with pressure injury stage 4, date initiated 12/31/2026, it indicated intervention to ensure the resident's comfort. During an observation on 2/4/2026 at 10:56 AM in Resident 7's room, Resident 7 was observed sitting in a broda chair. The broda chair was short for the resident, and the resident's feet were hanging with no proper support on the resident's lower leg (below the resident's knee). During a concurrent observation in Resident 7's room and interview on 2/4/2026 at 11 AM with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	License Vocational Nurse (LVN 2), LVN 2 stated Resident 7's broda chair was short for the resident, and Resident 7's feet were hanging. During a concurrent interview and record review on 2/5/2026 at 3:48 PM with the Director of Rehab (DOR), Resident 7's Physical Therapy Evaluation and Plan of Treatment was reviewed. DOR stated the Physical Therapy evaluation indicated Resident 7 was recommended for sitting up in broda chair to encourage socialization and relieve pressure/ support surface. DOR also stated, a broda chair that was short for the resident's height was not acceptable, and the chair should be the proper size and length to ensure there is no pressure on the resident's legs and the resident is comfortable. The DOR stated the resident's lower legs are not supposed to be hanging, as it could cause discomfort, poor circulation, a possible fall or sliding, or the development of a pressure ulcer. During an interview on 2/6/2026 at 3:04 PM with the Director of Nursing (DON), the DON stated that as soon as the facility staff found out the broda chair was too short, it should have been changed/ replaced. The DON also stated there was a lack of judgement and supervision and the facility staff did not change Resident 7's broda chair to a size that fits the resident. During a record review of the facility's Policy and Procedures (P&P) titled Support Surface Guidelines dated 2/2024, the facility's P&P indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk for skin breakdown. The P&P also indicated redistributing support surfaces are to promote comfort for all bed- or chairbound residents, promote circulation and provide pressure relief or reduction. 2. During a record review of Resident 34's admission Record, the admission Record indicated Resident 34 was initially admitted to the facility on [DATE] with diagnoses that included dementia, abnormalities of gait and mobility, and lack of coordination. During a record review of Resident 34's Order Summary Report dated 2/5/2026, indicated an order for half bilateral siderails (bed safety accessory consisting of two, half-length, adjustable metal or rigid plastic barriers, one attached to each side of the bed) for bed mobility (to move safely in bed) and transfers, ordered on 6/2/2025. During a record review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 34 required setup or clean-up assistance (helper sets up or cleans up) with eating and upper body dressing. The MDS indicated Resident 34 required supervision or touching assistance (helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completes activity) with oral and toileting hygiene, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 34 required partial/moderate assistance (helper does less than half the effort) with shower. The MDS indicated Resident 34 required setup or clean up assistance with bed mobility. During a record review of Resident 34's Care Plan for half side rails for bed mobility, revised on 5/7/2025, indicated the following interventions: May have half assistive side rails for bed mobility. May put side rail up during Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/4/2026 at 9:32 AM in Resident 34's room, Resident 34 was in bed, half bedside rail on the right side of the bed was observed in vertical (upward position). During a concurrent observation in Resident 34's room and interview on 2/5/2026 at 12:12 PM with Registered Nurse 1 (RN 1), RN 1 stated Resident 34 is in bed, and right half bedside rail was not in place and was positioned vertically. RN 1 stated Resident 34 has an order for both bedside rails for safety and per family's request. During an interview on 2/5/2026 at 3:45 PM with Certified Occupational Therapy Assistant 2 (COTA 2), COTA 2 stated Resident 34's half bedside rails should be positioned horizontally and not vertically while Resident 34 is in bed. COTA 2 stated the bedside rail can be positioned by staff vertically when Resident 34 has to get up from bed and must use the bedside rail as a grab bar. COTA 2 stated staff should position both bedside rails properly when Resident 34 is in bed. During an interview on 2/5/2026 at 3:53 PM with Licensed Vocational Nurse 3 (LVN 3) stated Resident 34 needs to have both bedside rails for safety. LVN 3 stated bilateral bedside rails for Resident 34 were ordered for bed mobility, and if one was not positioned properly, Resident 34 might fall from the bed. During a record review of the facility's P&P titled Bed Safety and Bed Rails, revised in August 2022, indicated consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. It also included some bedrails that are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. The P&P also indicated for the purpose of this policy bed rails include: a. side rails; b. safety rails; and c. grab/assist bars.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide adequate supervisions and assistant device such as front wheeled walker (FWW, a lightweight, foldable mobility aid with two fixed wheels on the front legs and rubber tips, designed to enhance stability and balance for users with limited mobility), and hourly monitoring for resident's whereabout related to wandering (aimless, disoriented, or repetitive walking by residents often leading to safety risks within the facility premises) for one (1) of two (2) sampled residents (Resident 41) reviewed for falls. On 2/4/2026 and 2/6/2026, Resident 41 was observed walking without an FWW. This deficient practice placed Resident 41 at risk for another fall which could lead to serious harm and injury to the resident.During a review of Resident 41's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), unsteadiness on feet and difficulty walking. During a review of Resident 41's Minimum Data Set (MDS- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 41's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 41 required set up or clean-up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 41 required supervision or touching assistance (helper provides verbal cues) with oral and personal hygiene. The MDS indicated Resident 41 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 41 required partial/moderate assistance with walking. During a review of Resident 41's Care Plan (CP), revised on 4/13/2025, it indicated Resident 41 was at risk for wandering/elopement (the act of leaving a facility unsupervised and without prior authorization) related to cognitive impairment and history of attempts to wander. The CP intervention indicated hourly monitoring for resident's whereabout related to wandering. During a review of Resident 41's CP, initiated on 4/13/2025, it indicated Resident 41 has potential for falls/injury related to history of falls, unsteady gait, and dementia. The CP interventions are the following:Assist with transfers and mobility as needed.Provide reminders to use ambulation and transfer assist devices as needed.The CP was revised on 1/20/2026 to indicate Resident 41's fall with no injury. During a review of Resident 41's Change in Condition (COC) Evaluation, dated 9/22/2025, timed 10:33 AM, Resident 41 had a fall in the hallway while trying to reach the hallway siderail. During a review of Resident 41's COC Evaluation, dated 11/9/2025, timed 1:10 PM, Resident 41 had a fall while ambulating, During a review of Resident 41's COC Evaluation, dated 11/23/2025, timed 1:30 AM, Resident 41 had a fall in the nursing station, Resident 41 stood up abruptly and lost her balance. During a review of Resident 41's COC Evaluation dated 1/19/2026, timed 4:34 AM, Resident 41 was found in another resident's room (room [ROOM NUMBER]), sitting upright on the floor, and leaning on the door frame. During an observation on 2/4/2026 at 3:21 PM, Resident 41 was observed walking in the hallway without an FWW and no facility staff present to monitor the resident. During an observation on 2/6/2026 at 8:38 AM, Resident 41 was observed walking in the hallway without an FWW and no facility staff present to monitor the resident. During an interview on 2/6/2026 at 12:14 PM with Physical Therapist Assistant (PTA), PTA stated Resident 41 have the tendency to walk and walk until she gets tired. PTA stated Resident 41 had multiple falls while in the facility, and Resident 41 was not using an FWW. PTA stated Resident 41 could have benefited from the use of FWW since the first fall in 9/22/2025, to maintain balance and help with maneuvering and turning with obstacles. During an interview on 2/6/2026 at 12:40 PM with Director of Rehabilitation (DOR), DOR stated Resident 41 was on rehabilitation services since after first fall in 9/22/2025, due to multiple falls and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was discontinued on 12/20/2025, with discharge summary of difficulty walking. DOR stated the use of FWW should have been taught and encouraged Resident 41 every time she was observed ambulating. DOR stated almost everyone in the facility knows that Resident 41 wanders and ambulates until the resident gets tired and Resident 41 would have benefited with the use of FWW to prevent any future falls and to maintain stability of the resident's gait. DOR also stated Resident 41 should have encouraged to use the FWW rather than walking hand in hand. During a concurrent record review and interview on 2/6/2026 at 4 PM with MDS nurse (MDSN), Resident 41's CP for potential for falls/injury related to history of falls, unsteady gait, and dementia date initiated was reviewed. MDSN stated Resident 41's fall CP that was initiated on 4/13/2025 was revised on 1/20/2026 to indicate Resident 41's fall incident on 1/19/2026. MDSN also stated the CP did not indicate it was revised after Resident 41 had a fall on 11/9/2025 and 11/23/2025. During the same concurrent record review and interview on 2/6/2026 at 4 PM with MDSN, Resident 41 CP for falls with injury related to poor safety awareness, Resident 41 has unspecified dementia initiated on 9/26/2025, and revised on 2/4/2026 indicated Resident 41 was forgetful at times leaving FWW and ambulate without using the FWW, with behavior of touching parallel bar when walking until the resident gets tired. MDNS stated Resident 41's CP was not revised when Resident 41 had fall incidents and should have been revised on 11/9/2025, 11/23/2025, and 1/19/2026. MDSN stated Resident 41's noncompliance with the use of FWW should have been in Resident 41's CP and interventions should have been developed to address the non-compliance. MDSN stated Resident 41 has a CP for wandering, and hourly monitoring intervention probably is not enough. MDSN is unable to provide documented evidence that Resident 41 was being monitored every hour. MDSN also stated, Resident 41's CP was not specific to the resident's needs to prevent resident from falling since Resident 41 had multiple fall incidents in the facility. During an interview on 2/6/2026 at 4:51 PM with the Director of Nursing (DON), the DON stated Resident 41 has a CP to be monitored every hour for wandering behavior, but there was no documentation that it was done. The DON also stated everyone knows that Resident 41 is a fall risk and admitted FWW was recently added on Resident 41's CP this year (2/4/2026), to indicate that Resident 41 sometimes forgets to use the FWW. The DON stated Resident 41 had multiple falls last year (9/22/2025, 11/9/2025 and 11/23/2025), and the use of FWW was not implemented on 2/4/2026 and 2/6/2026 and it should have been implemented to prevent Resident 41 from having another fall. The DON stated Resident 41 should have documentation for staff's monitoring of the resident's whereabouts every hour, so that the facility staff can determine Resident 41's pattern and determine an appropriate intervention in preventing fall incidents. During a review of facility's Policy and Procedure (P&P) titled, Falls-Clinical Protocol, revised in March 2018, indicated treatment/management is based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The P&P also indicated that if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). It is also indicated if the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the residents' falling (instead of, or in addition to those that have already been identified) and reconsider the current interventions. During a review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, indicated care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. It also indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a gastrostomy tube (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) received the tube feeding as indicated with the physician's order for one of three sampled residents (Resident 47) reviewed for tube feeding. This deficient practice had the potential to result in Resident 47 to not receive the volume of tube feeding formula ordered, which can lead to fluid overload (a condition where excess water and sodium accumulate in the body), difficulty of breathing that can lead to resident's hospitalization and/ or death. Findings: During a review of Resident 47's admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), gastrostomy status (the clinical condition of having an artificial, surgical opening [stoma] in the stomach, usually with a GT), and heart failure (a condition where the heart cannot pump blood efficiently, causing fluid buildup, fatigue, and shortness of breath). During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 47 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making. The MDS indicated Resident 47 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation with Licensed Vocation Nurse 3 (LVN 3), on 2/4/2026 at 9:12 AM, in Resident 47's room, Resident 47 was observed in bed, with ongoing GT feeding of Fiber source running at 60 milliliters (ml, unit of measurement) every hour. During a concurrent interview and record review on 2/5/2026 at 3 PM with Licensed Vocation Nurse 3 (LVN 3), Resident 47's active Physician's Orders dated from 9/13/2025 to 2/5/2026 were reviewed. LVN 3 verified, the GT feeding rate that was observed yesterday (2/4/2026) was wrong. LVN 3 stated Resident 47's current GT feeding order is Fiber source 1000 ml/1200 kilocalories (kcal, unit of measurement) at rate of 50 ml every hour for 20 hours or until dose met, off at 10 AM and start at 2 PM, ordered on 2/1/2026. LVN 3 stated that 60 ml every hour rate was Resident 47's previous order for the GT feeding rate before it was changed on 2/1/2026 to 50 ml every hour. LVN 3 stated the licensed nurses kept continuing the settings from the GT feeding pump (an automated medical device used to deliver liquid nutrition, fluids, or medication at a precise, controlled rate directly into a patient's stomach through a GT) and did not change the settings when the order was changed on 2/1/2026. LVN 3 stated it is important to follow GT feeding order to ensure resident's safety. LVN 3 also stated administering GT feeding more than the ordered volume can lead to fluid buildup that can affect Resident 47's breathing or accumulate fluid in the lungs which is life threatening that can lead to hospitalization. During an interview on 2/6/2026 at 2:19 PM with MDS nurse (MDSN), the MDSN stated it was important to follow the physician's order for the GT feeding rate to prevent change of condition such as shortness of breath, and abnormal vital signs due to complications like fluid overload. The MDSN stated not providing the ordered amount of GT feeding formula can lead to weight gain and harm to the residents. During a review facility's policy and procedures (P&P) titled, Enteral (through the intestines) Feeding - Safety Precautions, dated November 2018, it indicated to prevent errors in administration, check the enteral nutrition label against the order before administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management for one (1) of two (2) sampled residents (Resident 39) reviewed for pain on 2/3/2026 and 2/4/2026, in accordance with the physician's order and facility policy.This deficient practice resulted in Resident 39 not receiving pain medication as scheduled and experiencing unnecessary pain, which had the potential to affect the resident's overall wellbeing. Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included dorsalgia (general pain in the back), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and pyoderma gangrenosum (a rare skin disease characterized by rapidly progressing, intensely painful ulcers). During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 39 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 39 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, and personal hygiene. The MDS also indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, and upper body dressing. The MDS indicated Resident 39 was dependent (helper does all of the effort) with shower, lower body dressing and putting on/off footwear. The MDS indicated Resident 39 received scheduled and as needed pain medication, and non-medication intervention for pain. The MDS indicated Resident 39 was taking opioids (a class of powerful pain-relieving drugs). During a review of Resident 39's Order Summary Report, dated 2/5/2026, the Order Summary Report indicated the following:Morphine sulfate (a drug used to treat moderate to severe pain) oral solution 20 milligrams (mg, unit of measurement) per milliliter (ml, unit of measurement). Give 0.5 ml sublingually (SL, placing medication under the tongue to dissolve and absorb) every four (4) hours as needed for severe pain (scale 7-10) or shortness of breath. Ordered on 1/30/2026.Morphine sulfate extended release (ER) oral tablet 30 mg. Give 1 tablet by mouth every 12 hours for chronic lower back pain. Ordered on 2/4/2026. During a review of Resident 39's Change of Condition (COC) notes dated 2/4/2026, timed 2:44 PM, the COC notes indicated Resident 39 has increased pain, with pain scale rate of 7/10. The COC notes indicated Resident 39 verbalized increased generalized body pain and resident's pain is not managed by current pain regimen. During an observation on 2/4/2026 at 10:04 AM, in Resident 39's room, Resident 39 asked Licensed Vocational Nurse 3 (LVN 3) for pain medication. During an observation on 2/4/2026 at 10:35 AM, Resident 39 was heard screaming for pain medicine. Resident 39 appeared to be distressed. During a concurrent record review and interview on 2/5/2026 at 3:55 PM with LVN 3, Resident 39's medical records were reviewed. LVN 3 stated that on 1/30/2026, Resident 39 was admitted under hospice care (designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) and pain medications were ordered. LVN 3 stated that yesterday (2/4/2026), Resident 39 asked him for pain medication around 10 AM. LVN 3 stated Resident 39 received pain medication (morphine sulfate 20 mg SL) at 6:30 AM on 2/4/2026. LVN 3 stated LVN 4 administered morphine sulfate 20 mg SL to Resident 39 on 2/4/2026 around 10:30 AM since the order indicated that it could be given every four (4). During a concurrent record review and interview on 2/5/2026 at 4:16 PM with LVN 3, Resident 39's current medication administration record was reviewed. LVN 3 stated that morphine sulfate ER 30 mg oral tablet was not given on 2/3/2026 at 9 PM and 2/4/2026 at 9 AM as ordered. LVN 3 stated Resident 39's medication administration note, dated 2/3/2026, timed 9:18 PM, indicated morphine sulfate ER 30 mg was pending pharmacy delivery. LVN 3 added that Resident 39's medication administration note, dated 2/4/2026, timed 8:17 AM, indicated order (pain medication Morphine sulfate ER 30 mg oral tablet) was not delivered and that it will be followed up with hospice 1. LVN 3 stated Resident 39 missed 2 doses (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the morphine ER 30 mg tablet. LVN 3 stated that licensed nurses should ensure residents are not in pain by providing them medication and communicating resident's status to other staff that are involved in the care. LVN 3 stated licensed nurses could have informed hospice 1 what was available in the facility's emergency medication kit, and if there was a medication to substitute morphine 30 mg ER oral tablet while waiting for delivery. During an interview on 2/6/2026 at 1:05 PM with Hospice Nurse 1 (HN 1), HN 1 stated that he was never made aware on 2/3/2026 that medication of morphine 30 mg ER oral tablet was not delivered and Resident 39 missed a dose that evening of 2/3/2026. HN 1 further stated facility staff informed him today that Resident 39 missed 2 doses of morphine 30 mg ER oral tablet. During an interview on 2/6/2026 at 2:37 PM with the MDS Nurse (MDSN), the MDSN stated Resident 39 missed 2 doses of scheduled morphine 30 mg ER oral tablet on 2/3/2026 and 2/4/2026. The MDSN stated the licensed nurse should have contacted hospice 1 on 2/3/2026 and morning of 2/4/2026 to follow up. MDSN stated Resident 39 has chronic lower back pain and has been treated with morphine sulfate even prior to hospice care. The MDSN stated it was very important to administer pain medication as ordered to ensure Resident 39's comfort. During an interview on 2/6/2026 at 4:56 PM with the Director of Nursing (DON), the DON stated when Resident 39 was admitted to hospice 1 on 1/30/2026, Resident 39 was ordered with scheduled morphine sulfate 60 mg ER oral tablet every 12 hours for pain management. The DON stated that a lower dose of morphine 30 mg ER oral tablet every 12 hours was ordered for Resident 39 on 2/3/2026, but the medication was not delivered, and Resident 39 did not receive 2 scheduled doses. The DON stated that licensed nurses did not and should have informed HN 1 regarding the unavailability of the Resident 39's medication. During a review of Facility's P&P titled, Pain Assessment and Management, dated October 2022, the P&P indicated to establish a treatment regimen that is specific to the resident based on consideration of current medication regimen. The following are considered when establishing the medication regimen:Administering medications around the clock rather than PRN.Combining long-acting medications with PRNs for breakthrough pain.It also indicated the medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to complete the Physician Discharge Summary (PDS) form for one of three sampled residents (Resident 61) reviewed for close record. This deficient practice has the potential to result in increased Resident 61's chances of re-injury after discharge home, medication errors (any preventable event that may cause or lead to inappropriate medication use or patient harm while), and improper follow-up care.Findings:During a review of Resident 61's admission Record indicated Resident 61 was admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric fracture of left femur subsequent encounter for closed fracture with routine healing (The bone near hip joint area, broken hip, has broken into two or more pieces that have shifted out of alignment. occurring on the left side, where the broken bone fragments have shifted, requiring follow-up care), encounter for other orthopedic aftercare (follow-up, post-surgical, or rehabilitative visits for musculoskeletal conditions), and unspecified atrial fibrillation (an irregular, often rapid heart rate where the specific type has not been determined). During a review of the Minimum Data Set (MDS- a resident assessment tool) dated 11/30/2025, it indicated Resident 61's cognitive decision is severely impaired (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 61 is dependent (helper does all of the effort) with toileting hygiene, shower, bathe self, lower body dressing, putting on/ taking off footwear, change of position, and transfer. It also indicated Resident 61 need partial or moderate assistance, (helper does less than half the effort) with oral hygiene, personal hygiene, and upper body dressing. During a review of physician discharge summary (PDS) dated 12/22/2025, PDS did not indicate Resident 61's condition on discharge and prognosis on discharge. During a concurrent interview and record review on 2/6/2026 at 8:45 AM with Medical Record (MR), PDS dated 12/22/2025 was reviewed. The PDS indicated Resident 61's condition and prognosis on discharge was left blank. MR stated she was the one responsible for the PDS form to make the doctor complete and sign the PDS form. During a concurrent interview and record review on 2/6/2026 at 9:15 AM with Discharge Planner (DP), DP stated it is MR's responsibility to monitor the completion of PDS. During a concurrent interview and record review on 2/6/2026 at 12:55 PM with the Director of Nursing (DON), Resident 61's PDS dated 12/22/2025 was reviewed. The DON stated MR should have obtained doctor's note for Resident 61's condition on discharge and prognosis upon the resident's discharge and before the doctor signed Resident 61's PDS. The DON also stated this is also licensed nurse's responsibility to verify with doctor for Resident 61's condition and prognosis on discharge at the time of Resident 61's discharge to home to make sure the discharge document is complete. During a review of the facility's policy and procedures (P&P) titled, Transfer or Discharge, Facility-Initiated dated 10/2022, the P&P indicated should the resident be transferred or discharged for any reasons, the basis for the transfer or discharge is documented in the resident 's clinical record by the resident's attending physician (doctor) including the transfer or discharge is appropriate because the resident's health has improved sufficiently so the residents no longer needs the services provided by the facility. The P&P also indicated, the following information is documented in the resident's medical records:A summary of the resident's overall medical, physical and mental condition.Other's as appropriate as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (4) residents in each room. room [ROOM NUMBER] has five (5) residents and 5 beds.This failure had the potential for the residents' care and services not to be adequately accommodated and could have an adverse effect on the residents' safety and place the residents at risk for lack of privacy.Findings:During an observation on 2/4/2026 at 10 AM, room [ROOM NUMBER] was observed to have 5 beds in the room with all 5 beds observed to be occupied. During a review of the facility's room waiver dated 2/4/2026, the facility's room waiver indicated the following:Room Sq. Ft. (square feet - unit of measurement) Bedsroom [ROOM NUMBER] - 511 sq. ft. - 5 bedsDuring an interview on 2/6/2026 at 11:39 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated all the rooms at the facility have enough room for her to provide care safely to the residents. During an interview on 2/6/2026 at 11:44 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated that all the resident rooms at the facility have enough room for her to provide care to the residents and that the residents also have enough room to move around safely. During an interview on 2/6/2026 at 11:47 AM with CNA 4, CNA 4 stated all the resident rooms have enough space for the residents to get around & also have enough room for her to provide care to the residents safely.During an interview on 2/6/2026 at 1:29 PM with the Administrator (ADM), ADM stated room [ROOM NUMBER] has 5 beds and 5 residents in the room. The ADM stated room [ROOM NUMBER] did not meet the requirement of only 4 residents in one room. ADM stated he will continue to apply for the room waiver since it does not affect the health and safety of the residents and there is enough space in the room for the staff to provide care for the residents safely.During a review of the facility's room waiver letter, dated 4/6/2026, the facility's room waiver letter 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 or stored in the rooms that can prevent access.The Department recommends the room waiver for room [ROOM NUMBER].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056201	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Healthcare Center	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)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 14 of 24 resident rooms (rooms 108, 109, 110, 111, 112, 114, 200, 201, 202, 203, 204, 206, 211 and 215) met the square footage requirement of 80 square feet (sq. ft. - unit of measurement) per resident in a multiple resident rooms. This failure had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care.Findings:During an observation on 2/4/2026 from 10 AM to 1PM, rooms 108, 109, 110, 111, 112, 114, 200, 201, 202, 203, 204, 206, 211 and 215 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate and/or move around in their wheelchairs freely. Nursing staff were observed to have enough space to provide safe quality care and there was enough space for beds, side tables, dressers and other medical equipment. During a review of the facility's room waiver dated 2/4/2026, the facility's room waiver indicated the rooms with 2 beds are in accordance with the needs of the residents with adequate space and do not have any adverse effects on the residents' health and safety. The facility's room waiver also indicated the following:Room Sq. Ft. Bedsroom [ROOM NUMBER] - 156.51 sq. ft. - 2 bedsroom [ROOM NUMBER] - 159.33 sq. ft. - 2 bedsroom [ROOM NUMBER] - 156.51 sq. ft. - 2 bedsroom [ROOM NUMBER] - 159.04 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155.4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155.4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155.4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 157.62 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155.4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 158.2 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155. 4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 155.4 sq. ft. - 2 bedsroom [ROOM NUMBER] - 159.33 sq. ft. - 2 bedsroom [ROOM NUMBER] - 159.33 sq. ft. - 2 bedsThe minimum square footage for a 2-bedroom is 160 sq. ft. During an interview on 2/6/2026 at 11:39 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated all the rooms at the facility have enough room for her to provide care safely to the residents. During an interview on 2/6/2026 at 11:44 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated that all the resident rooms at the facility have enough room for her to provide care to the residents and that the residents also have enough room to move around safely. During an interview on 2/6/2026 at 11:47 AM with CNA 4, CNA 4 stated all the resident rooms have enough space for the residents to get around & also have enough room for her to provide care to the residents safely.During an interview on 2/6/2026 at 1:29 PM with the Administrator (ADM), ADM stated rooms 108, 109, 110, 111, 112, 114, 200, 201, 202, 203, 204, 206, 211 and 215 do not meet the requirement of 80x80 sq. ft. per resident and that they will continue to apply for the room waiver since it does not affect the health and safety of the residents.During interviews with residents both individually and collectively, they did not express any concerns regarding the size of their rooms. The Department would be recommending the room waiver for Rooms 108, 109, 110, 111, 112, 114, 200, 201, 202, 203, 204, 206, 211 and 215 as requested by the facility.