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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315343	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway House for Continuing Care	298 Broadway Newark, NJ 07104

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and facility policy review, r the facility failed to ensure residents were free of abuse for one of one resident reviewed for abuse (Resident (R) 3) out of 21 sampled residents. R3 was physically abused by R119. This failure placed the resident at risk for physical injury and psychosocial harm. Findings include: Review of a facility policy titled Abuse, dated 01/01/25 indicated .Physical Abuse.Any inappropriate physical contact with a resident, such as hitting, slapping, striking with an open or closed hand, pinching, biting, kicking, rough handling, pulling of hair, twisting of limbs, or punching. Review of a document provided by the facility titled Resident Face Sheet indicated R3 was admitted to the facility on [DATE]. Review of a document provided by the facility titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident was moderately cognitively impaired. Review of a document provided by the facility titled Resident Face Sheet indicated R119 was admitted to the facility on [DATE]. Review of a document provided by the facility titled nursing Progress Notes dated 08/09/24 indicated R3 was overheard by Licensed Practical Nurse (LPN) 1 when R3 and R119 were arguing. The progress notes revealed by the time LPN1 approached the two residents, R119 hit R3 twice in the face. LPN1 separated R119 from R3. LPN1 assessed R3 and he sustained no injuries. Both the physician and the responsible party were notified of the resident-to-resident incident. An order was obtained to transfer R119 to a crisis unit, and initially R119 voiced that he did not want to go but then spoke with a family member and R119 complied. A review was conducted of R119's clinical records and there were no prior aggressive/physical behaviors identified with other residents. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a document provided by the facility titled Summary of Investigation dated 08/09/24 indicated a resident-to-resident incident which involved R3 and R119. The facility's investigation revealed R119 had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The investigation indicated R3 was sitting in his wheelchair and in front of the nursing station when R119 approached R3 and stepped on his right foot and punched him twice in the face. As part of the facility's investigation the Director of Nursing (DON) watched camera footage of the incident between R3 and R119 and verified the resident-to-resident incident. The investigation revealed R3 was placed one-on-one and R119 was sent to the emergency room for crisis intervention and was eventually transferred back to the facility on [DATE]. During an interview on 02/18/25 at 2:03 PM, LPN1 confirmed she witnessed R119 hit R3. LPN1 confirmed R119 was sent to another facility. LPN1 verified she heard R3 tell R119 to hit him, and when she began to go towards the two residents, she witnessed R119 hit R3 twice in the face. LPN1 stated she considered the resident-to-resident abuse and reported the incident immediately to her supervisor. LPN1 confirmed she was interviewed by the DON as part of the facility's investigation. A subsequent interview was conducted on 02/19/25 at 8:50 AM, LPN1 verified R119 was immediately sent out to the emergency room to be evaluated by a crisis team and considered resident-to-resident abuse. LPN1 stated R119 was eventually transferred to another facility. During an interview on 02/19/25 at 11:44 AM, R3 confirmed R119 stepped on his foot but did not remember if he was hit in the face. R3 stated he believed the actions made by R119 were abuse. R3 stated he was not fearful of R119. During an interview on 02/19/25 at 1:12 PM, the DON stated her expectation was to protect R3 and the staff provided him with one-on-one supervision. The DON stated both R3 and R119 had counseling related to the incident. The DON stated there were no prior incidents which involved R119 and other residents. The DON stated R119 was placed on the first floor and R3 was on the second floor. During a subsequent interview on 02/19/25 at 3:24 PM, the DON and the Administrator were present. The DON stated R119's attack on R3 was unprovoked. The DON stated the goal was to keep R3 protected, and we wanted to make sure no one suffered any triggers as a result of the resident-to-resident, and this was why both residents received counselling after the incident. NJAC 8:39-4.1(a)5 NJAC 8:39-9.4(f)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622 Based on interview, record review, and policy review, the facility failed to ensure two of two residents discharged to the hospital (Resident (R) 51 and R57) out of a total sample of 21 residents were provided with a bed hold notice within 24 hours of emergent transfer to the hospital. This failure increased the potential that residents would not know to request a bed hold and may be unable to return to the facility. Findings include: Review of the facility's policy titled Bed-Holds and Returns dated 01/01/25 revealed the following Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy (3) Prior to a transfer, written information will be given to the residents and resident representatives that explains in detail: (a) the rights and limitations of the resident regarding bed-holds; (b) the reserve bed payment policy as indicated by the state plan (Medicaid Residents) (c) the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid Residents); and (d) the details of the transfer (per the Notice of Transfer). 1. Review of R57's undated Admission Record, located in the resident's electronic medial record (EMR) under the Resident Summary tab revealed R57 was admitted to the facility on [DATE]. Review of R57's Progress Note located in the EMR under the Resident Summary tab dated 07/28/24 revealed the following resident in bed with fever. Resident lethargic with elevated heartrate on 2L oxygen via nasal canula. Vitals: BP 122/89, HR 138, Temp 101.8, Resp 22, Sat 95%, Resident skin flush and hot to touch, no complaint of shortness of breath or pain. Nurse notified supervisor and the medical director (MD). The MD notified staff to send resident out to hospital to r/o [rule out] sepsis. Tylenol 650mg given prior to transport to hospital. Family notified. Review of R57's Progress Note dated 08/05/24 located under the Resident Summary tab of the EMR revealed Resident readmitted to the facility at 3:00 pm . 2. Review of R51's Admission Record located in the resident's EMR under the Resident Summary tab revealed R51 was admitted on [DATE]. Review of R51's Progress Note dated 01/04/25 and located in the resident's EMR under the Resident Summary tab revealed Resident tolerated all due meds, observed with a discoloration bump on the right side of the head. MD made aware, ordered to send resident to the ER for CT SCAN of the head. A review of the EMR did not reveal any evidence to indicate R51 received a bed hold notice. During an interview on 02/19/25 at 10:42 AM, the Director of Nursing (DON) stated the facility did not provide the residents and/or their representatives with a bed hold policy when they were sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 1:58 PM, the Business Office Assistant (BOA) stated they do not provide the residents or their representatives with a bed hold policy when they are sent to the hospital. NJAC 8:39-4.1(a)31 NJAC 8:39-5.1 NJAC 8:39-5.3(b)

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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** 12679 Based on observation, interview, and record review, the facility's failed to have an adequate water management program. The facility's water management program was incomplete and was not consistent with current ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) Guideline, which specifically called for design and maintenance procedures for the potential exposure of Legionnaire's disease (a serious pneumonia infection) within a healthcare facility. This failure created the potential for the 65 facility residents, who were either over the age of 65 and/or were autoimmune compromised, to be infected by Legionella. Findings include: Review of website for ASHRAE titled Successfully Managing the Risk of Legionellosis dated 04/07/21 indicated . Legionellae the biological classification name for a [NAME] of bacteria.is the plural, referring to more than one Legionella bacterium.Legionellosis: any illness (disease) caused by the exposure to Legionella. Legionnaires' disease (LD) and Pontiac fever (PF) are the two known types of legionellosis. Potentially fatal, multisystem respiratory illness, accompanied by pneumonia.Symptoms.high fever, chills, muscle pain, headache, dry cough, diarrhea, vomiting, confusion, and delirium common.Immune suppressed. transplant patients, cancer, cardiac, diabetes, steroid/drug therapy.Sick/in poor health. Elderly/infirm.Heavy smokers, lung/COPD diseases.Describe the building water systems using flow diagrams & a written description: Include details such as where the building connects to the (municipal) water supply, how water is distributed and used (processed), where hot tubs, water heaters, cooling towers, etc. are located. Review of a document provided by the facility titled Water Management Plan and Procedure for Broadway House for Continuing Care (BHCC) undated indicated .The purpose of this Water Management Plan (WMP) is to ensure the safe and reliable delivery of water to all areas of the nursing home, with a focus on maintaining the health and safety of residents and staff, preventing waterborne illnesses, and managing water resources efficiently. The facility failed to ensure their water management program contained a diagram or a description of the building's water system. During an interview on 02/19/25 at 9:16 AM, the Maintenance Director stated he tested water temperatures on a daily basis as part of the facility's water management program. The Maintenance Director stated there was no diagram of the facility's water system which would identify potential areas for water pathogen development. The Maintenance Director stated there were no schematics of the building's water system. The Maintenance Director stated he would need to reach out to the owners of the building to see if they had any additional information. During an interview on 02/19/25 at 3:24 PM, the Administrator stated he had been recently hired as an interim Administrator and said his expectations were to monitor the facility's water management program, which included reviewing the facility's water system. NJAC 8:39-19.1(a)(b) NJAC 8:39-19.4