

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/01/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey.</p> <p>Complaint Number: CA00959625</p> <p>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>One deficiency was issued for the complaint number: CA00959625 (Refer to F686).</p>	F 000	<p><i>Preparation and/or execution of this response and Plan of Correction (POC) do not constitute an admission or agreement by the provider of truth or accuracy of alleged facts or conclusions set forth in this Statement of Deficiencies. This POC is prepared and/or executed solely for provisions of Federal and State required regulations. This POC is not an admission of noncompliance with cited regulation(s)</i></p>	
F 686 SS=E	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to intervene and document wound care prevention and management according to professional standards of practice and per the facility ' s policy and procedure titled, "Skin and Wound Monitoring and</p>	F 686	<p>F686 Corrective Action</p> <p>Resident 1: was discharged on 12/3/2024. Resident 2: returned from the hospital on 4/29/25. Treatments are in place for all skin conditions.</p> <p>Identification of Others at Risk</p> <p>All residents of this facility that have skin conditions, have the potential to be affected by this deficiency.</p> <p>The Medical Records Director has reviewed the TAR's for the month of May. 16 Active residents with skin condition were identified. Treatment orders were documented, no further follow needed..</p> <p>The DON has reviewed the TARs for the month of May and compared skin conditions identified upon admission against the TAR for 8 active residents. Skin conditions identified upon admission had treatment orders in place. No further follow up was needed.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 5/22/25
--	-------------------------------	-----------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 1</p> <p>Management," for 2 of 3 sampled residents (Residents 1 and 2) by failing to:</p> <ol style="list-style-type: none"> 1. Document wound care treatments ordered by the physician in the treatment record for Resident 1. 2. Document Resident 2 ' s wound measurements upon admission. 3. Order and treat Resident 2 ' s moisture associated skin damage (MASD - skin damage caused from prolonged exposure to moisture) upon admission. <p>These deficient practices had the potential to cause harm to Resident 1 and Resident 2 by worsening their wounds/skin conditions, due to lack of accountability, not ascertaining a baseline to monitor worsening of a wound, and the possibility of not providing treatments as ordered which could cause wounds to worsen. These deficient practices also had the potential to cause skin breakdown by not providing preventative treatment typical to the standard of care.</p> <p>Findings:</p> <p>a. During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on 9/24/2024 with diagnoses including pressure ulcer/injury stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region (lower back), cognitive communication deficit (communication difficulties arising from problems with cognitive processes like attention, memory, and problem-solving rather than speech or</p>	F 686	<p>Process to Prevent Recurrence</p> <p>The DON has inserviced the licensed nurses and the Skin IDT Committee members between 5/16/25 and 5/20/25 on the facility policy Skin And Wound Monitoring and Management, including identifying and documenting skin conditions upon admission and starting those treatments timely, and the need to document skin treatments when provided on the TAR.</p> <p>The Medical Records Director will review the TARs daily (M-F) x30 days for completion. Results will be forwarded to the DON for needed follow up.</p> <p>The DON/Designee will review daily (M-F) newly admitted residents to ensure that identified skin conditions have treatment orders in place.</p> <p>Monitoring Process</p> <p>The DON will provide results of the daily skin reviews to the QA&A committee during the monthly meeting x 3 months.</p> <p>Quality Assessment & Assurance and Continuous Quality Improvement Committee will monitor compliance by review of finding and actions/resolutions taken during the monthly meeting x 3 months.</p> <p>Complete Date: 5/20/2025</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	<p>Continued From page 2</p> <p>language issues), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment and was dependent on staff for toileting hygiene and personal hygiene.</p> <p>During a review of Resident 1 ' s Skin Evaluation Note, dated 9/24/2025, the Skin Evaluation Note indicated Resident 1 was admitted to the facility with a pressure ulcer/injury stage 4 of the sacral coccyx (lower back).</p> <p>During a review of Resident 1 ' s Physician ' s Order, dated 11/8/2025, the Physician ' s Order indicated to cleanse the sacral coccyx pressure ulcer/injury stage 4 with normal saline (a saltwater solution), pat dry, apply medical-grade honey (treatment used to debride [a medical procedure that involves removing dead, infected, or damaged tissue from a wound or surgical site] bad tissue from wounds) to the wound bed (the base or open area of a wound), and cover with foam (designed to manage an ideal wound environment for healing) dressing daily, ordered on 11/8/2025.</p> <p>During a review of Resident 1 ' s Treatment Administration Record (TAR), dated 11/2024, the TAR indicated there was no documentation indicating treatments were provided to Resident 1 ' s sacral coccyx on 11/8/2024 and 11/24/2024 as ordered.</p> <p>b. During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was</p>	F 686		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 3</p> <p>originally admitted to the facility on 11/16/2024 and readmitted on 4/29/2025 with diagnoses including need for assistance with personal care, muscle weakness, cognitive communication deficit, and dementia.</p> <p>During a review of Resident 2 ' s MDS, dated 11/20/2024, the MDS indicated Resident 2 had severe cognitive impairment and was dependent on staff for toileting hygiene, showering/bathing, and dressing. The MDS further indicated Resident 2 was at risk for developing pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) during the assessment period.</p> <p>During a review of Resident 2 ' s LN Initial Admission Record, dated 11/16/2024, the LN Initial Admission Record indicated Resident 1 had MASD of sacral region left and right buttocks.</p> <p>During a review of Resident 2 ' s Physician ' s Orders, dated 11/19/2024, the Physician ' s Orders indicated to apply zinc oxide barrier cream (a protective barrier that helps prevent moisture loss from the skin and enhances the healing process of wounds) daily to bilateral (both sides) buttocks for MASD ordered on 11/19/2024.</p> <p>During a review of Resident 2 ' s Licensed Nursing (LN) Initial Admission Record (Nursing Assessment), dated 4/29/2025 and timed at 4 p.m., the LN Admission Record indicated Resident 2 was admitted with a sacral wound. The LN Initial Admission Record did not indicate the size or wound type.</p> <p>During an observation on 4/30/2025 at 10:02 a.m., with Licensed Vocational Nurse (LVN) 1, in</p>	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	<p>Continued From page 4</p> <p>Resident 2 ' s room, Resident 2 had redness with excoriations (raw, irritated skin) on her bilateral buttocks. LVN 1 stated Resident 2 was readmitted yesterday, and she had not yet evaluated her skin and therefore did not know if the excoriations were new or not.</p> <p>During an interview on 4/30/2025 at 12:15 p.m., with LVN 1, LVN 1 stated MASD occurs when a resident has been sitting in their urine and/or feces for a long period which eventually leads to irritation and skin breakdown. LVN 1 stated Resident 2 had MASD upon her original admission on 11/16/2024 which has been ongoing, and a skin barrier should have been applied right away to prevent more irritation but was not ordered until 11/19/2024.</p> <p>During an interview on 4/30/2025 at 2:58 p.m., with the Director of Nursing (DON), the DON stated if a resident has MASD she would expect a barrier cream to be ordered to protect the skin. The DON stated Resident 2 received an order for a barrier cream on 11/19/2024, three days after the MASD was identified upon admission on 11/16/2024. The DON stated it should not have been ordered three days later.</p> <p>During a follow-up interview on 5/1/2025 at 11:10 a.m., with the DON, the DON stated Resident 2 was admitted on 4/29/2025 but measurements for the wound on her sacral region were not done. The DON stated the admitting nurse should document the measurement of wounds upon admission so the team could have a baseline to see if the wound got worse or not and then make a short-term care plan until they come up with a care long term plan. The DON stated Resident 1 ' s physician orders for his wounds were ordered</p>	F 686		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 5</p> <p>daily and should be documented. The DON stated if it was not documented they cannot be sure if it was done or not and could cause a wound to get worse.</p> <p>During an interview on 5/1/2025 at 1:49 p.m., with Physician Assistant (PA) 1, PA 1 stated if a resident had MASD the typical treatment would be to apply barrier cream the same day, and it should not take three days to intervene with this type of treatment unless there was a good medical reason.</p> <p>During an interview on 5/1/2025 at 2:20 p.m. with LVN 1, LVN 1 stated although she worked at the facility prior to 11/2024, she changed roles from a charge nurse to a treatment nurse on 11/7/2024. LVN 1 stated during that time in 11/2024 she was being trained as a treatment nurse. LVN 1 stated she never missed providing wound care treatment for any of her residents and is not sure why Resident 1 ' s sacral wound care for 11/8/2024 and 11/24/2024 was not documented in the TAR.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled "Skin and Wound Monitoring and Management," dated 3/2015, the P&P indicated the purpose of the policy was to promote interventions that prevent pressure ulcers, promote healing of pressure ulcers that are present, and provide care and services to prevent the development of additional, avoidable pressure injuries. The P&P further indicated the nurse responsible for assessing and evaluating the resident ' s condition on admission and readmission is expected to take the following actions:</p>	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055894	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 6 a. Assess and evaluate the resident ' s condition and is expected to identify factors related to the possibility of skin breakdown or the development of pressure ulcers which include exposure of skin to urinary or fecal incontinence and co-morbid conditions. b. Risk factors identified should be documented in the clinical record and be addressed through the care plan. c. A licensed nurse will document the measuring of the skin injury and staging of the skin when necessary. d. Treatments per physician order should be documented in the resident ' s clinical record at the time they are administered. e. Any changes in the condition of the resident ' s skin as identified daily, weekly, monthly, or otherwise must be communicated to the resident/responsible party, the resident ' s physician, and others as necessary to facilitate healing. f. Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area per the Physician ' s Order.	F 686			