

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

PRINTED: 06/10/2025
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 05/27/2025
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NAME OF PROVIDER OR SUPPLIER BROADWAY BY THE SEA	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 E. BROADWAY LONG BEACH, CA 90803
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health (CDPH) during an abbreviated standard survey for two complaints.</p> <p>Complaint Numbers: CA00962305 and CA00963426</p> <p>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.</p> <p>No deficiencies were issued for complaint number: CA00963426.</p> <p>One deficiency was issued for complaint number: CA00962305. See F550</p>	F 000	<p>reparation and/or execution of this re- sponse 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)</p>	
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,</p>	F 550	<p>F550 Corrective Action Assigned CNA was inserviced 1:1 by DSD on 05/27/25 on Resident Rights, including the importance of keeping the call light within reach at all times. Assigned LVN was inserviced 1:1 by DSD on 05/27/25 on Resident Rights, including the importance of keeping the call light within reach at all times.</p> <p>Identification of Others at Risk All residents of this facility have the potential to be affected by this deficiency. The DSD has made observation rounds on 05/27/25 on call lights being within reach. All call lights were within reach.</p>	

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

 ADMINISTRATOR 06/12/25

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.

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F 550	<p>Continued From page 1</p> <p>severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one of three sampled resident's (Resident 1) call light (a device used by residents to call for assistance from facility staff) was within reach.</p> <p>This deficient practice resulted in Resident 1 looking for but not being able to locate find her call light. This deficient practice had the potential for Resident 1 to get out of bed without assistance causing a fall and injury.</p> <p>Findings:</p>	F 550	<p>Process to Prevent Recurrence</p> <p>The DON and DSD have inserviced nursing and facility staff between 05/27/25 and 05/30/25 on Resident Rights, including the importance of keeping the call light within reach at all times.</p> <p>The Guardian Angels will observe the placement of the call lights during their routine rounds. Results will be reported to Administrator for any needed follow up.</p> <p>Monitoring Process</p> <p>The Administrator will provide results of the observation rounds to the QA&A committee during the monthly meeting. Quality Assessment & Assurance and Continuous Quality Improvement Committee will monitor compliance by review of finding and actions/resolutions taken during the monthly meeting x3 months.</p> <p>Complete Date: 06/12/25</p>	

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F 550	Continued From page 2 During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on 2/10/2024 with diagnoses including neurocognitive disorder with Lewy bodies (progressive brain disease that causes a decline in thinking abilities), adult failure to thrive (decline in their overall health and well-being) and a history of falls. During a review of Resident 1's History and Physical (H&P), dated 2/11/2024, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/7/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was severely impaired. During a review of the Resident 1's Care Plan, revised on 5/10/2025, the Care Plan indicated Resident 1 was at risk for falls related to abnormalities in gait (how a person walks) and balance, a history of falls, dementia (a progressive state of decline in mental abilities), shortness of breath (SOB), a seizure disorder, a history of dizziness, psychotherapeutic medication (medication that affects how one thinks and feels), a need for assistance with activities of daily living ([ADLs] activities such as	F 550			

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F 550	<p>Continued From page 3</p> <p>bathing, dressing and toileting a person performs daily) adult failure to thrive and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that interferes with daily life). The Care Plan's goals indicated Resident 1 would minimize her risk of falls/injuries through the next review date of 8/7/2025. The Care Plan's interventions included placing Resident 1's call light within reach and encouraging Resident 1 to use it to call for assistance as needed.</p> <p>During an observation accompanied by the Assistant Director of Nursing (ADON) and concurrent interview on 5/27/2025, at 8:27 a.m., Resident 1 was observed lying in bed looking around for something. Resident 1 stated she was looking for her call light but could not find it. Resident 1's call light was observed between Resident 1's mattress and the fitted sheet toward the top of the bed. The ADON stated, there was no way Resident 1 could reach the call light to ask for assistance and it (the call light) should be accessible to the resident for safety reasons. The ADON stated Resident 1 was at high risk for falls and without the call light, she was unable to call for assistance which increased her risk of falling and injuries.</p> <p>During an interview on 5/9/2024 at 3:30 p.m., the DON stated call lights should be accessible to residents so they could receive care in a timely manner. The DON stated Resident 1's risk for falls and injuries was increased when she does not have a means to ask for assistance, which could result in her trying to get out of bed without assistance and falling.</p>	F 550			

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F 550	Continued From page 4 During a review of the facility's undated Policy and Procedure (P/P), titled, "Call Light/Bell" the P/P indicated it is the policy of the facility to provide the resident a means of communicating with nursing staff. The P/P indicated the staff should place the call device within the resident's reach before leaving the room.	F 550			