STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055894	A. BUILDING _____ B. WING _____	**04/08/2020**

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

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were answered promptly to meet residents' needs, and that facility staff provided residents assistance for three of three sampled residents (Residents 1, 3, and 4). This deficient practice had the potential to neglect the resident's well-being, and to result in the residents' needs not being met timely by the facility's staff. Findings: A review of the facility's Resident Council minutes dated October 2019 indicated the residents complained about the staff's failure to answer call lights for the evening shift 3 p.m. to 11 p.m. and the night shift 11 p.m. to 7 a.m. A review of the facility's document titled, Falling Star Program dated October 2019 indicated a total of 6 unwitnessed falls, with 1 repeat fall. A review of the facility's document titled, Falling Star Program dated November 2019 indicated a total of 15 unwitnessed falls including a fall for Resident 3, with 5 repeat falls and 1 death. On 12/3/19 at 9:30 a.m., during a tour of the facility, the call light for room [ROOM NUMBER] was heard continuously ringing in Nursing Station 2. Registered Nurse Supervisor (RN 1), two Licensed Vocational Nurses (LVNs 1 and 2), and a Social service assistant (SSA) was observed sitting at Nursing Station 2, while the call light was audibly ringing continually for nine minutes without responding to the call light. On 12/3/19 at 9:40 a.m., the call light in room [ROOM NUMBER] was observed ringing continuously in Station 2, while RN 1, LVN 1 and the SSA remained seated without responding to the call light. Resident 1 , who was ringing the call light stated he had been wet for 40 minutes. Resident 1 stated the nursing staff has not responded to the call light, or checked on his well-being. Resident 1 stated the facility's staff just come in and turn off the call light without tending to his needs. Resident 1 stated he was left soiled for long periods of time. In a subsequent observation on 12/3/19 at 9:55 a.m., the DON and LVN 1 entered room [ROOM NUMBER]. The DON conducted a physical assessment of Resident 1's soiled bottom. Resident 1 was observed with a soiled adult brief containing semi solid feces. Resident 1's buttocks were observed with opened bright red skin and a newly acquired skin tear after the DON assessed Resident 1, in the presence of LVN 1. The DON stated the skin tear was newly acquired. a. A review of Resident 1's Admission Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's admission Minimum Data Set (MDS), a resident assessment and care screening tool, dated 10/26/19 indicated Resident 1 had no memory problems, no impaired decision-making, was able to make needs known and understand others. According to the MDS, Resident 1 was assessed as being two-person physical assist with bed mobility, transferring, locomotion on and off the unit, requiring limited assistance with eating and extensive assistance with personal hygiene. A review of Resident 1's care plan initiated on 10/19/19, identified a problem with risk for pressure sores due to right [MEDICAL CONDITION]. The goal indicated Resident 1 would be free of skin breakdown. The staff's interventions were to keep the resident clean and dry, monitor for signs of skin breakdown, turn the resident every two hours, and to use pressure relieving device on bed. A review of Resident 1's care plan initiated on 10/19/19, identified a problem with incontinence (lack of voluntary control over urination). The goal indicated Resident 1 would be free of skin breakdown daily until next review date. The staff interventions were to provide good perineal (the area between the thighs) care. On 12/3/19 at 10:08 a.m., during an observation of Nursing Station 1, LVN 4 was observed in the hallway standing close to room [ROOM NUMBER], while LVN 3 was observed sitting in a chair while call light was audibly ringing continually for four minutes without staff responding. At 10:12 a.m. on 12/3/19, LVN 4 was observed entering room [ROOM NUMBER], turned off the call light and exited the resident's room. In a concurrent interview LVN 4 stated the resident in room [ROOM NUMBER] is only pressing the call light because he (Resident 3) wants a bed bath. According to LVN 4 she was busy, and told Resident 3 to wait for his assigned CNA. b. On 12/3/19 at 10:13 a.m., during an interview, Resident 3 stated the reason he was ringing his call light was to request salt and pepper and a cup of ice for his breakfast. Resident 3 denied requesting a bed bath from LVN 4. A review of Resident 3 Admission Face Sheet indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's annual MDS, dated [DATE] indicated Resident 3 had no memory problems, no impaired decision-making, was able to make needs known and understand others. According to the MDS, Resident 3 was assessed as requiring extensive assistance with bed mobility, transferring, and personal hygiene, and required limited assistance with eating. A review of Resident 3's care plan initiated 11/27/19, identified a problem with requiring assistance with ADLs (activities of daily living) due to multiple medical conditions including dysphagia and [MEDICAL CONDITION]. The focus included Resident 3 requiring assistance with bed mobility, eating, toileting, and hygiene. The goal indicated that Resident 3's needs would be met and anticipated by the staff every shift. The interventions were to keep call light in reach, and answer promptly. On 12/3/19 10:17 a.m., during an interview with LVN 3 in the presence of the DON, LVN 3 stated she did not hear the call light ringing for room [ROOM NUMBER] while sitting in the nursing station. In a subsequent interview at 10:18 a.m., on 12/3/19 the DON stated she is not sure why the staff was not answering call lights. The DON stated Its everyone's responsibility to answer the call lights, not just to go inside the resident's room and turn the call light off. 12/3/19 at 10:24 a.m., during an observation a Certified Nursing Assistant (CNA 1) was observed entering room [ROOM NUMBER] with a cup of ice for Resident 3. According to CNA 1, the licensed nurses do not respond to the call lights. CNA 1 stated the nurses turn off the call lights and come to tell the nursing assistants what the resident needs. On 12/3/19 at 10:37 a.m., LVN 2 stated when the call lights were ringing, she was on the telephone helping with doctor appointments, and was unable to respond to the call lights. According to LVN 2 the CNA was told to answer the call light, but there were a lot of call lights ringing at the same time. LVN 2 stated it was everyone's responsibility to answer call lights. On 12/3/19 at 10:43 a.m., during an interview, LVN 4 stated she was busy passing medications while the call light for room [ROOM NUMBER] was ringing. LVN 4 stated she turned off the call light because she told the resident (Resident 3) his assigned CNA (CNA 1) would be in to help. LVN 4 admitted she did not communicate with CNA 1 regarding Resident 4 pressing the call light for help, and did not ask Resident 3 what he needed at that time. c. On 12/3/19 at 11:10 a.m., during an interview, Resident 4 stated when he presses the call light the staff ignore him for up to two hours at times. Resident 4 stated he was left soiled for long periods at a time. According to Resident 4 the staff in the evening, and overnight leave him soiled until the morning shift arrives to clean him. Resident 4 stated when he complains to the Social Service staff he was told to request not to have certain staff assigned to his room. A review of Resident 4's Admission Face Sheet indicated Resident 4 was admitted to the facility on [DATE]. Resident 4 's [DIAGNOSES REDACTED]. A review of Resident 4 's admission MDS, dated [DATE] indicated Resident 4 had no memory problems, no impaired decision-making, was able to make needs known and understand others. According to the MDS, Resident 4 was assessed as requiring extensive assistance with bed mobility, transferring, and personal hygiene, and required limited assistance with eating. A review of the facility's policy titled, Answering the Call Light dated 10/2010, indicates the purpose of this procedure is to respond to the resident's request and needs. Answer the resident's call light as soon as possible. Listen to the resident's request and do what the resident asks of you, if permitted. If you have promised the resident you will return with an item of information, do so promptly.

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

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.