

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/07/2024
NAME OF PROVIDER OR SUPPLIER  Coral Cove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1730 Grand Ave Long Beach, CA 90804	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45891</p> <p>Based on observation, interview, and record review the facility failed to developed a comprehensive plan of care for one of four sampled residents (Resident 1) for the potential of impaired vision in the right eye and the actual vision loss in the left eye due to diagnosis of glaucoma (eye disease that can cause vision loss and blindness) and advanced diabetic retinopathy (complications of diabetes that affects patient ' s eye that can lead to blindness) upon admission.</p> <p>This deficient practice resulted in delay of services for Resident 1 including the need for eye specialist referrals or monitoring for a decline in eyesight. Resident 1 had a decreased vision in the right eye leading to right eye vision loss.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes (a condition in which the body fails to process glucose (sugar) correctly ) with proliferative diabetic retinopathy (complications of diabetes that affects patient ' s eye that can lead to blindness), blindness on left eye, normal vision right eye, primary open-angle glaucoma (a chronic and irreversible eye condition that causes gradual vision loss) and depression.</p> <p>During a review of Resident 1 ' s Admission Summary dated 10/26/2023, the Admission Summary indicated Resident 1 was admitted to the facility for osteomyelitis (bone infection) and for continued wound care and treatment with antibiotics (medication for infection) due to right trans metatarsal amputation (a surgical procedure that removes part of the foot) The Admission Summary indicated Resident 1 informed the IP that his vision was impaired, and requested an optometrist ' s consult. The Admission Summary indicated Resident 1 was able to transfer with minimal assistance/supervision from staff.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 11/2/2023, the MDS indicated Resident 1 had moderate impairment in cognitive skills (ability to think, understand, learn, and remember) for daily decision making. The MDS indicated Resident 1 had moderately impaired vision (limited vision; not able to see newspaper headlines but can identify objects). The MDS indicated it was very important for Resident 1 to choose what clothes to wear and to take care of his personal belongings. The MDS indicated Resident 1 needed set-up or clean-up assistance (staff sets up or cleans up; resident completes activity) for eating, dressing upper body, toileting, and showering.</p> <p>During a review of Resident 1 ' s care plan, titled The resident has impaired visual function related to cataracts (a cloudy area that develops in the lens of the eye, causing vision loss), diabetes, disease process, at risk for complications developed on 3/20/2024 (5 months after admission on 10/26/2023) the goals for Resident 1 included not to have any acute eye problems, not to have a decline in right visual function, and to maintain optimal quality of life within limitation imposed by right visual function. The Care Plan indicated the interventions included to arrange consultations with eye care practitioner (physician) as required, and monitoring/ documenting/ reporting any signs or symptoms of acute right eye problems (sudden visual loss, double vision, tunnel vision [medical condition that makes someone see only things that are directly in front of them], blurred or hazy vision).</p> <p>During an interview on 9/3/2024 at 2:01 p.m., Resident 1 stated he had been asking multiple facility staff members including the Infection Preventionist (IP), Social Service Director (SSD) 1 and charge nurse (not specified) to send him out to his eye specialist (MD 2) since the day he got to the facility on [DATE]. Resident 1 stated he came to the facility with a left eye cataract and blindness, but his right eye vision was intact. Resident 1 stated he had been seeing an outside retinal specialist (MD 2) prior coming to the facility and he needed to have a follow up appointment.</p> <p>During a concurrent observation and interview on 9/4/2024 at 9:15 a.m., Resident 1 was sitting in his wheelchair at his bedside trying to open his bedside drawer. Resident 1 was fumbling around trying to find the drawer knob and knocked his hair gel on the floor and yelled. Resident 1 was unable to see the hair gel on the floor and required assistance to pick it up. Resident 1 had an electric razor in his hand and stated he was going to shave himself off memory and then he would have certified nursing assistant (CNA 1) come in and fix any spots he missed and to help him pick out clothes.</p> <p>During an interview on 9/5/2024 at 12:02 p.m., the MDSN stated Resident 1 should have a care plan regarding his impaired vision when he was first admitted to the facility or the potential for decreased eyesight due to his diagnoses of diabetes and diabetic retinopathy. The MDSN stated a vision care plan was important to ensure the resident was going to all appointments needed for the eyes and to ensure all the resident ' s needs were met. The MDSN stated she was unable to locate a vision care plan for Resident 1 upon admission and there was no vision care plan initiated until 3/20/2024.</p> <p>During an interview on 9/5/2024 at 4:38 p.m., the DON stated care plans were important to dictate and manage a resident ' s care and Resident 1 should have had a vision care plan since admission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled Diabetic Care dated 1/1/2012, the P&amp;P indicated the Interdisciplinary team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) was to ensure the care plan addressed the resident ' s diabetes, goals, and interventions and regular eye care exam education was to be provided to the resident.</p> <p>During a review of the facility ' s P&amp;P titled Comprehensive Person-Centered Care Planning dated 9/7/2023, the P&amp;P indicated the comprehensive care plan was to contain all goals, objectives, interventions for the resident. The P&amp;P indicated the care plan was to include resident-specific health and safety concerns to prevent any decline or injury.</p> <p>(Cross reference: F684)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45891</p> <p>Based on observation, interview, and record review, the facility failed to ensure, the resident who had intact (not impaired) right eyesight did not lose eyesight and became blind, for one of four sampled residents (Resident 1).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure licensed nurses acted upon and carried out the optometrist 's (specialized health care profession that involves examining the eyes and related structures for defects or abnormalities) [OPT 1]) recommendations made on 3/22/2024 for Resident 1 to see a retina (the light sensitive lining of the eye) specialist (medical doctor who specialized in disease of the retina) and a glaucoma specialist (medical doctor who specialized in glaucoma [eye disease that can cause vision {state of being able to see} loss and blindness]). Resident 1 was not seen by retina specialist (MD 2) until 8/1/2024 (132 days later) and was seen by the glaucoma specialist (MD 3) on 8/27/2024 (158 days later).</li> <li>2. Ensure Social Services Director (SSD 1), Case Management (CM 1), and licensed nurses informed Resident 1 's primary physician (MD 1) of OPT 1 's recommendations to see retina and glaucoma specialists for the right eye blurred vision, obtained MD 1 's order and followed through with scheduling and arranging Resident 1 's appointment to see retina and glaucoma specialist to prevent the resident 's right eye vision loss.</li> <li>3. Ensure Resident 1, who was admitted to the facility on [DATE] with an intact (not impaired) right eye vision, had a comprehensive plan of care for the potential of impaired vision in the right eye due to diagnosis of advanced diabetic retinopathy (complications of diabetes [a condition in which the body fails to process glucose (sugar) correctly ] that affects patient 's eye that can lead to blindness) with interventions to prevent vision loss.</li> </ol> <p>These deficient practices resulted in Resident 1 's decreased vision in the right eye leading to right eye vision loss and blindness. Resident 1 developed depression (a mood disorder that can cause a persistent feeling of sadness and loss of interest in activities) requiring medical treatment, became isolated (having minimal contact from his family and lost his independence in activities of daily living ([ADLs] activities related to personal care).</p> <p>On 9/6/2024 at 1:59 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider 's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called due to the facility 's failure to prevent a decline in Resident 1 's right eye vision in the presence of the Director of Nursing (DON), Director of Staffing (DSD), and the facility 's Regional Nurse Consultant (RNC).</p> <p>On 9/7/2024 at 11:40 a.m., the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility 's IJRP 's implementation through observation, interview, and record review, the IJ was removed on 9/7/2024 at 4:50 p.m., in the presence of the DON and RNC.</p> <p>The IJRP included the following immediate actions:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. On 8/27/2024, Resident 1 was seen and evaluated by Ophthalmologist (eye care specialist) and recommendations for follow-up appointments/treatments have been carried out as indicated. A follow up appointment was scheduled for 9/19/2024.</p> <p>2. On 8/1/2024 and 8/26/2024, Resident 1 was seen and evaluated by Retina Specialist and recommendations for follow-up appointments/treatments have been carried out as indicated. A follow up appointment was scheduled for 9/30/2024.</p> <p>3. On 9/6/2024, Resident 1 ' s plan of care related to vision was reviewed by the interdisciplinary team ([IDT] a team that provides integrated care) and was updated accordingly.</p> <p>4. On 9/6/2024, the DON/Designee provided an in-service (training done during your time at work, to learn new skills) education to the infection preventionist nurse (IP), SSD 1, CM 1 and the licensed nurses on duty regarding the policy and procedures for Ancillary Services (diagnostic and supportive measures that help healthcare providers treat residents) , with emphasis on the importance of reviewing recommendations from ancillary services and ensure physician was notified and recommendations are carried out and followed through. The in-service will be completed by 9/11/2024. Licensed Nurses on leave or unscheduled will receive education upon return to work. SSD 1 is responsible for locating agencies and programs that meet the needs of residents, facilitating the execution of service provider contracts, and referring residents to existing contracted providers. For clinical services, a nursing designee will assist SSD 1 in locating a provider. Referrals for medical services are only made pursuant to an Attending Physician ' s order.</p> <p>5. The Director of Social Services or his or her designee will coordinate with Nursing Staff to ensure that the Attending Physician ' s order and referral to outside provider is documented in the resident ' s medical record.</p> <p>6. Facility Process related to Ancillary Services:</p> <p>a. Upon licensed nurse ' s receipt of new ancillary service referral orders from the attending physician, the licensed nurse will print a copy of the referral order and place the copy in the Referrals/Appointments Binder located in each nurse ' s station.</p> <p>b. For outside Ancillary Services appointments already scheduled by the licensed nurse as ordered by the attending physician, a copy of the appointment order will be placed in the Referrals/Appointments Binder.</p> <p>c. Social Services and Case Manager will review the Referrals/Appointments Binder every morning on weekdays for any new referral orders.</p> <p>d. Social Services will arrange for in-house ancillary visits and/or outside ancillary appointments as indicated.</p> <p>e. For any outside ancillary appointments requiring prior authorization (process that health insurance companies use to determine if a medical treatment or service is medically necessary before it can be provided) from the insurance, the Case Manager will submit the request for prior authorization.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>f. Upon resident ' s return from outside ancillary appointment, the licensed nurse will review the ancillary service progress notes written by the specialist for any recommendations.</p> <p>g. New recommendations from the ancillary service will be relayed by the licensed nurse to the resident ' s attending physician for further orders.</p> <p>h. New orders from the attending physician will be carried out by the licensed nurse.</p> <p>i. Upon completion of in-house ancillary visit, the specialist progress report(s) will be gathered by the Social Services and a copy will be provided to the licensed nurse to ensure that any recommendations are relayed to the resident ' s attending physician.</p> <p>7. During Daily Clinical Meetings on Mondays to Fridays, the DON, Social Services, and Case Manager will review the following:</p> <p>a. New Ancillary Services progress notes to ensure that all recommendations from the ancillary services are relayed to the attending physicians and are followed through in a timely manner; and</p> <p>b. Referrals/Appointments Binder for new referrals to Ancillary Services to ensure that the referrals are followed through.</p> <p>c. Any appointments or other recommendations pending completion will continue to be reviewed during these meetings by the DON, and Social Services, and Case Manager. All actions/interventions taken related to Ancillary Services will be documented in residents ' clinical records.</p> <p>8. Ancillary Service Tracking Log will continue to be maintained by Social Services and will be reviewed regularly to ensure consults remain current.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes (a condition in which the body fails to process glucose (sugar) correctly ) with proliferative diabetic retinopathy (complications of diabetes that affects patient ' s eye that can lead to blindness), blindness on left eye, normal vision right eye, primary open-angle glaucoma (a chronic and irreversible eye condition that causes gradual vision loss) and depression.</p> <p>During a review of Resident 1 ' s Admission Summary dated 10/26/2023, the Admission Summary indicated Resident 1 was admitted to the facility for osteomyelitis (bone infection) and for continued wound care and treatment with antibiotics (medication for infection) due to right trans metatarsal amputation (a surgical procedure that removes part of the foot) The Admission Summary indicated Resident 1 informed the IP that his vision was impaired, and requested an optometrist ' s consult. The Admission Summary indicated Resident 1 was able to transfer with minimal assistance/supervision from staff.</p> <p>During a review of Resident 1 ' s Physician ' s Order Summary dated 10/26/2023 the Physician ' s Order Summary indicated an order for eye health, vision consult, and follow up with treatment as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 11/2/2023, the MDS indicated Resident 1 had moderate impairment in cognitive skills (ability to think, understand, learn, and remember) for daily decision making. The MDS indicated Resident 1 had moderately impaired vision (limited vision; not able to see newspaper headlines but can identify objects). The MDS indicated it was very important for Resident 1 to choose what clothes to wear and to take care of his personal belongings. The MDS indicated Resident 1 needed set-up or clean-up assistance (staff sets up or cleans up; resident completes activity) for eating, dressing upper body, toileting, and showering.</p> <p>During a review of Resident 1 ' s care plan, titled The resident has impaired visual function related to cataracts (a cloudy area that develops in the lens of the eye, causing vision loss), diabetes, disease process, at risk for complications developed on 3/20/2024 (5 months after admission on 10/26/2023) the goals for Resident 1 included not to have any acute eye problems, not to have a decline in right visual function, and to maintain optimal quality of life within limitation imposed by right visual function. The Care Plan indicated the interventions included to arrange consultations with eye care practitioner (physician) as required, and monitoring/ documenting/ reporting any signs or symptoms of acute right eye problems (sudden visual loss, double vision, tunnel vision [medical condition that makes someone see only things that are directly in front of them], blurred or hazy vision).</p> <p>During a review of Resident 1 ' s Visit Summary Note from OPT 1 dated 3/22/2024, the Visit Summary Note indicated OPT 1 prescribed new eye medications as follows:</p> <ol style="list-style-type: none"> <li>1. Rocklatan eye drops (medication used to treat high intraocular pressure [IOP] the pressure or force of fluid inside the eye) at bedtime instill (put) into bilateral (both) eyes.</li> <li>2. Combigan eye drops (medication used treats high IOP) twice daily instill into bilateral eyes.</li> <li>3. Acetazolamide oral ([given by mouth] medication used to treat high IOP) one tablet twice a day.</li> </ol> <p>The Visit Summary Note indicated Resident 1 reported to OPT 1 he used to take eye drops medication but had not been using them (unknown reason why). The Visit Summary Note indicated OPT 1 stressed tight compliance with medications to preserve his (Resident 1 ' s) current vision and that the resident needed a referral to a glaucoma specialist. The Visit Summary Note indicated at the time of evaluation on 3/22/2024, Resident 1 had 20/40 (sees things at 20 feet that most people who do not need vision correction can see at 40 feet) vision in the right eye enabling the resident to see and move around on his own. The OPT 1 recommended a follow up with retina specialist on next available appointment.</p> <p>During a review of Resident 1 ' s Social Services Note dated 4/1/2024, written by SSD 1, the Social Services Note indicated Resident 1 stated he gave the social services assistant (SSA) phone number to schedule an appointment with his eye doctor (as was recommended by OPT 1).</p> <p>During a review of Resident 1 ' s Social Services Note dated 4/3/2024, the Social Services Note indicated SSA called Resident 1 ' s eye doctor to inquire about the code (not documented what code) that Resident 1 misplaced. The Social Services Notes indicated no documentation of appointment arrangement or future contacts with the eye doctor regarding Resident 1 ' s follow up appointment with the eye doctor after SSA ' s documented entry on 4/3/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s in-house (in the facility) Ophthalmology (eye doctors who perform medical and surgical treatments for eye conditions) Exam/Consult and Report Note dated 4/16/2024, the Ophthalmology Exam/ Consult and Report Note indicated the goal for Resident 1 ' s was to maintain quality of life and vision preservation. The Ophthalmology Exam/ Consult and Report Note indicated Resident 1 was being followed by OPT 1 for eye drops and management of both eyes pressure control (Resident 1 was not seen again by OPT 1 after the appointment on 3/22/2024).</p> <p>During a review of Resident 1 ' s change of condition ([COC] a sudden or gradual change in a resident ' s physical, cognitive, behavioral, and functional status) note dated 6/30/2024, the COC note indicated Resident 1 complained of blurry vision in both eyes and was seeing lights and shapes. The COC note indicated MD 1 ordered a STAT (as soon as possible) Comprehensive Metabolic Panel ([CMP] laboratory test).</p> <p>During a review of Resident 1 ' s Nurses Progress Notes dated 6/30/2024, the Nurses Progress Notes indicated Resident 1 called 911 (emergency medical services) on 6/30/2024 and complained of blurry vision. Resident 1 was taken to a general acute care hospital (GACH). Resident 1 was sent back from the GACH with a diagnosis of eye irritation the same day (6/30/2024).</p> <p>During a review of Resident 1 ' s Transfer to Hospital Summary dated 6/30/2024, the Transfer to Hospital Summary indicated Resident 1 called 911 himself due to blurry vision and feeling blind and was transferred to the GACH.</p> <p>During a review of Resident 1 ' s GACH ' s Emergency Department (ED) Documentation dated 6/30/2024, the GACH ' s ED Documentation indicated Resident 1 was seen in the ED with the chief complaint of right eye vision changes since 6/28/2024. The GACH ' s ED Documentation indicated Resident 1 felt as though something was stuck in his right eye but was uncertain. The GACH ' s ED Documentation indicated Resident 1 ' s eyes were irrigated (flush), and he was diagnosed in the ED with eye irritation. The ED physician (MD 5) wrote in the ED</p> <p>Documentation that he called the facility multiple times with no answer to request more information about Resident 1 ' s medication prior to discharge from the GACH. The GACH ' s ED Documentation Discharge Instructions for Resident 1 indicated for Resident 1 to follow up with MD 1, ophthalmologist, and return to the ED for any worsening vision symptoms. The GACH ED Documentation indicated a diagnosis of eye irritation.</p> <p>During a review of Resident 1 ' s Nurses Progress Notes dated 7/1/2024, the Nurses Progress Notes indicated Resident 1 needed insurance authorization (process that health insurance companies use to determine if a medical treatment or service is medically necessary before it can be provided) to see an ophthalmologist (MD 4). The Nurse ' s Progress Notes indicated CM 1 was notified and would follow up on insurance authorization.</p> <p>During a review of Resident 1 ' s Nurses Progress Notes dated 7/2/2024, the Nurses Progress Notes indicated MD 4 ' s office informed the facility staff that MD 4 did not accept Resident 1 ' s medical insurance. The Nurses Progress Notes indicated CM 1 and SSD 1 were notified.</p> <p>During a review of COC note dated 7/5/2024, the COC note indicated Resident 1 was going to the restroom and tripped over something on the floor without injuries noted.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Physician Order Summary, dated 7/8/2024 the Physician Order Summary indicated an order for ophthalmology consult due to Resident 1 ' s witnessed fall on 7/5/2024 related to glaucoma.</p> <p>During a review of Resident 1 ' s Nurses Progress Notes dated 7/9/2024, the Nurses Progress Notes indicated the insurance authorization was received for Resident 1 to see MD 4 and it was faxed to MD 4 ' s office. The Nurses Progress Note indicated staff was to follow up on MD 4 ' s office on the next business day (7/10/2024) to schedule an appointment. The Nurses Progress Notes indicated there was no documented information regarding a follow-up with MD 4 ' s office to schedule Resident 1 ' s appointment, not until 7/15/2024.</p> <p>During a review of Resident 1 ' s COC note dated 7/15/2024, the COC note indicated Resident 1 was complaining of increased blurry vision (COC note did not specify which eye) and Resident 1 verbalized his eyesight was getting worse. The COC note indicated LVN 4 called MD 4 ' s office and faxed over the insurance authorization.</p> <p>During a review of Resident 1 ' s Physician ' s Order Summary, dated 7/16/2024 the Physician ' s Order Summary indicated an order for an appointment with retina specialist (MD 2) on 8/1/2024 at 2 p.m.</p> <p>During a review of Resident 1 ' s Psychiatric Evaluation Note dated 7/18/2024, indicated Resident 1 expressed he was stressed because I am going blind. The Psychiatric Evaluation Note indicated Resident 1 ' s Zolof (antidepressant medication) was increased from 50 milligram ([mg] a unit of measurement) ordered on 4/28/2024 to 100 mg by mouth daily ordered on 7/18/2024.</p> <p>During a review of Resident 1 ' s MDS dated [DATE], the MDS indicated Resident 1 had intact cognition and had moderate impaired vision. The MDS indicated Resident 1 needed set-up or clean-up assistance for eating, dressing upper body, and toileting. The MDS indicated Resident 1 required supervision or touching assistance for showering.</p> <p>During a review of Resident 1 ' s Visit Summary from the retina specialist (MD 2) on 8/1/2024, the MD 2 ' s Visit Summary indicated Resident 1 ' s IOP in the right eye was 29 millimeters of mercury ([mmHg] a unit of measurement; normal IOP between 10 and 21 mmHg). The MD 2 ' s Visit Summary indicated Resident 1 received two urgent intravitreal injection ([[NAME]]) injections that are used to treat a variety of retinal conditions) in the right eye during the appointment on 8/1/2024. The MD 2 ' s Visit Summary indicated MD 2 recommended a follow up appointment in three weeks for pan-retinal photocoagulation ([PRP] a laser treatment that is the standard intervention for patients with proliferative diabetic neuropathy). The MD 2 ' s Visit Summary indicated Resident 1 received two injections in his right eye (Bevacizumab [medication for specific eye disease] 10 mg and Intravitreal injection for diabetic retinopathy with macular (part of the retina at the back of the eye) edema [happens when blood vessels leak into part of the retina, causing swelling]) during the visit. The MD 2 ' s Visit Summary indicated that on 8/1/2024 Resident 1 was newly diagnosed with neovascular glaucoma ([NVG] a serious type of glaucoma that can lead to blindness or vision loss) of the right eye.</p> <p>During a review of Resident 1 ' s Psychiatric Evaluation dated 8/16/2024, indicated Resident 1 expressed concern about his eyes and vision. The Psychiatric Evaluation indicated on 8/16/2024, Resident 1 ' s Zolof was increased to 150 mg daily for depression as manifested by increasing feelings of hopelessness and helplessness.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s MD 2 ' s Visit Summary dated 8/26/2024, the MD 2 ' s Visit Summary indicated MD 2 requested a glaucoma evaluation as soon as possible and recommended retina specialist follow up, and plan for tube surgery (small flexible tube placed in eye to relieve pressure and drain fluid) versus cyclophotocoagulation ([CPC] a laser that reduces eye pressure and treats glaucoma) for the right eye. The MD 2 ' s Visit Summary indicated Resident 1 ' s right eye IOP on 8/26/2024 was 46 mmHg (normal IOP between 10 and 21 mmHg).</p> <p>During a review of glaucoma specialist (MD 3) Visit Summary dated 8/27/2024, the MD 3 ' s Visit Summary indicated Resident 1 was complaining of flashing lights (signs that can indicate a serious medical condition that may result in permanent vision loss), watery eyes, and the right eye pain. MD 3 ' s Visit Summary indicated Resident 1 had an increased IOP in both eyes, and the treatment goal was to bring the right eye IOP down below 21 mmHg and comfort care (a type of medical care that focuses on relieving pain and other symptoms to improve the quality of life for patients) for the left eye. MD 3 ' s Visit Summary indicated Resident 1 had developed new vitreous hemorrhage ([VH] blood in the center of the eye) and NVG in the right eye since he was last seen by specialist (MD 2) on 7/2023. MD 3 ' s Visit Summary indicated Resident 1 developed new blurred vision a few weeks ago (unspecified date). The Visit Summary indicated MD 3 recommended to schedule tube shunt surgery (a type of glaucoma drainage implant that's used in a surgical procedure to reduce pressure on the optic nerve [responsible for transmitting visual information] and prevent vision loss) with corneal patch (a surgical procedure that can be used in conjunction with tube shunt surgery to treat glaucoma) of the right eye as soon as possible.</p> <p>During a review of Resident 1 ' s Physician ' s Order dated 8/27/2024, the Physician ' s Order indicated recommend right eye urgent glaucoma tube shunt surgery.</p> <p>During a review of Resident 1 ' s Physician ' s Order, the Physician ' s Order dated 9/5/2024 indicated Resident 1 was scheduled for emergency right eye tube shunt surgery with corneal patch on 9/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/3/2024 at 2:01 p.m., Resident 1 stated he had been asking multiple facility ' s staff including the IP, SSD 1, and charge nurse (not specified) to send him out to his eye specialist (MD 2) since the day he got to the facility on [DATE]. Resident 1 stated he came to the facility with a left eye cataract and blindness, but his right eye vision was intact. Resident 1 stated he had been seeing an outside retinal specialist (MD 2) prior to coming to the facility and he needed to have a follow up appointment. Resident 1 expressed his concerns to IP, SSD 1, and charge nurse (not specified). Resident 1 stated he was not seen by an outside optometrist (OPT 1) until 3/22/2024 and OPT 1 recommended to see a retina specialist and glaucoma specialist. Resident 1 stated the facility never made the appointment. Resident 1 stated, in June 2024, his right eye vision worsened and now he is blind on both eyes. Resident 1 stated he felt very sad that he cannot see his grandkids football games and does not visit his grandkids anymore because he does not want his family to see him blind. Resident 1 stated he would no longer be able to see the joy on his grandkids faces so he would rather not go to visit them. Resident 1 expressed feeling depressed due to being blind. Resident 1 stated the psychiatrist increased his antidepressant medication Zoloft and he was able to pull himself out of that dark place but still felt depressed. Resident 1 stated he was able to finally see MD 2 and MD 3 in August (8/1/2024 and 8/26/2024 with MD 2, and 8/27/2024 with MD 3) and had a scheduled surgery to place a shunt in his right eye to relieve pressure. Resident 1 stated MD 3 informed him that the surgery may or may not improve his eyesight but felt it was worth to try. Resident 1 stated he was so upset with the facility because he informed multiple facility staff members including the IP, SSD 1, and unspecified charge nurses and no one took him seriously until he got Licensed Vocational Nurse (LVN 4) involved. Resident 1 stated LVN 4 got him an appointment quickly to see MD 2. Resident 1 stated the facility just does not understand that they caused his blindness.</p> <p>During a concurrent observation and interview on 9/4/2024 at 9:15 a.m., Resident 1 was sitting in his wheelchair at his bedside trying to open his bedside drawer. Resident 1 was fumbling around trying to find the drawer knob and knocked his hair gel on the floor and yelled. Resident 1 was unable to see the hair gel on the floor and required assistance to pick it up. Resident 1 had an electric razor in his hand and stated he was going to shave himself off memory and then he would have certified nursing assistant (CNA 1) come in and fix any spots he missed and to help him pick out clothes.</p> <p>During an interview on 9/4/2024 at 11:42 a.m., LVN 4 stated Resident 1 used to be able to see with right eye but now he cannot see on both eyes. LVN 4 stated Resident 1 now required more help with ADLs and needed assistance to open his meal tray when he was able to do that by himself when he was first admitted to the facility on [DATE]. LVN 4 stated Resident 1 was a younger guy and tried his best to be independent even with the worsening eyesight, but now Resident 1 required more help. LVN 4 stated Resident 1 verbalized being upset and depressed due to his worsening eyesight. LVN 4 stated she called Resident 1 ' s health insurance and obtained a list of physicians that they covered since they did not cover MD 4. LVN 4 stated she put herself in the resident ' s shoes and pictured how she would feel if she was losing her eyesight and made it her goal to get Resident 1 an appointment as soon as possible (started working on appointment since 7/2024). LVN 4 stated she was not sure if the appointment would have been scheduled if she was not the one calling the health insurance and getting insurance authorization. LVN 4 stated maintaining vision was very important for physical well-being and decreased vision could exacerbate Resident 1 ' s depression.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/4/2024 at 12:34 p.m., SSD 1 stated her role with scheduling appointments was to ensure the resident had transportation to the appointment and the nursing staff was responsible for scheduling appointments. SSD 1 stated, SSA no longer worked at the facility. SSD 1 stated on 4/2024, Resident 1 gave a phone number for his eye specialist to SSA to help him schedule the appointment and it was not done. SSD 1 stated she talked to SSA about that situation because the nurses were supposed to make the appointments not the SSA or SSD 1. SSD 1 stated when a doctor recommended a specialist, a physician ' s order should have been entered in Resident 1 ' s medical record right away, but it was not done by the nursing staff.</p> <p>During an interview on 9/4/2024 at 12:57 p.m., CM 1 stated nursing staff must get the recommendations from the physician, then nursing staff must enter in Resident 1 ' s medical record the physician ' s orders and communicate with CM 1 that an appointment was needed, and insurance authorization was required. CM 1 stated if licensed nurses do not communicate a physician ' s order for scheduling an appointment was placed, CM 1 would not know insurance authorization was required. CM 1 stated the meaning of next available appointment meant right away.</p> <p>During concurrent interview and record review on 9/5/2024 at 3 p.m., the DON reviewed the Visit Summary from OPT 1 dated 3/22/2024 and confirmed there was a recommendation for Resident 1 to see a retina and glaucoma specialist as soon as possible. The DON stated there were no orders placed after Resident 1 ' s visit with OPT 1 on 3/22/2024 for either a retina specialist or glaucoma specialist and there was no documentation in Resident 1 ' s medical records informing MD 1 for retina and glaucoma specialist evaluation as requested by OPT 1. The DON stated the licensed nurse receiving the After Visit Summaries when resident (in general) returned from an appointment should review the document in its entirety to ensure no recommendations were missed. The DON stated this was not done by the licensed nurse after Resident 1 ' s visit with OPT 1 on 3/22/2024.</p> <p>During an interview on 9/5/2024 at 8:43 a.m., MD 2 stated he began seeing Resident 1 in April of 2023 for diabetic retinopathy and Resident 1 was receiving injections and laser treatment (medical procedure to treat some types of glaucoma) to stop bleeding in the eyes. MD 2 stated he last saw Resident 1 in July of 2023 and Resident 1 was blind on the left eye, but he had 20/15 (can see things at 20 feet that people with normal 20/20 vision can see at 15 feet) vision in the right eye. MD 2 stated there was a large gap in seeing Resident 1 and when Resident 1 was seen on 8/1/2024, here was bleeding in the right eye and Resident 1 had lost his right eye vision. MD 2 stated Resident 1 does have glaucoma and advanced diabetic retinopathy but there were treatments such as medications, injections in the eye, and laser treatments that can stop the bleeding in the eye. MD 2 stated, theoretically, if Resident 1 was seen sooner, his right eyesight could have been preserved and the progression of his eye disease slowed down.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/5/2024 at 9:36 a.m., Resident 1 stated he was angry and felt like no one was doing anything to address his concerns of his worsening eyesight. Resident 1 stated when OPT 1 saw him in March 2024, OPT 1 wanted Resident 1 to see the retina specialist. Resident 1 stated the SSD 1 was supposed to set him up with the retina specialist but acted like she could not find the phone number of the retina specialist. Resident 1 stated he was getting so mad at the facility staff because he did not want his vision to get worse so he would yell at staff sometimes. Resident 1 stated that on 6/30/2024, he still had not seen any specialist for his eyes and he started getting extreme eye pain and his vision was increasingly blurred. He felt as though the facility was not taking him seriously, so he called 911 on 6/30/2024 and was taken to the GACH. Resident 1 stated GACH only washed his eyes with water and told him he needed to see an ophthalmologist and sent him back to the facility because they (GACH) did not know his eye medical history. Resident 1 stated, a few days went by (unknown date in July 2024) and his eyes started watering bad and got even more blurry, so he got upset with the facility staff. Resident 1 stated the DON met with him and SSD 1 and he voiced that his vision was getting worse, and he was upset because he had been telling staff that he needed to see the specialist, and no one was taking him seriously and now he was going blind. Resident 1 stated he still was not getting anywhere with the appointments until LVN 4 got involved in mid-July, when LVN 4 obtained an appointment for him with MD 2. Resident 1 stated that he can no longer see his clothes to pick them out, and usually asks CNA 1 to help him pick clothing from his closet. Resident 1 stated his appearance was very important to him and he always took pride in what he was wearing. Resident 1 stated he felt embarrassed, and he cannot even see what he looked like. Resident 1 stated he would rather not see his family until his eyesight issues were sorted out. Resident 1 stated the facility was not taking him seriously when he informed them about his worsening eyesight and the need to see retina specialist.</p> <p>During an interview on 9/5/2024 at 12:02 p.m., the Minimum Data Set Nurse (MDSN) stated Resident 1 should have a care plan regarding impaired vision when he was first admitted or the potential for decreased eyesight due to his diagnoses of diabetes and diabetic retinopathy. The MDSN stated a vision care plan was important to ensure the resident was going to all needed appointments for the eyes and to ensure all the resident ' s needs were met. The MDSN stated she was unable to locate a vision care plan for Resident 1 upon admission and there was no vision care plan initiated until 3/20/2024. The MDSN stated Resident 1 ' s MDS dated [DATE] was coded as the resident had a moderately impaired vision because he could see but it was not clear. The MDSN stated Resident 1 complained about complete vision loss in August 2024, so</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45891</p> <p>Based on observation, interview and record review the facility failed to ensure one out of four sampled residents (Resident 1) ' s right eye intact vision was not deteriorated, and the resident did not lose right eye vision and became blind.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure licensed nurses acted upon the optometrist ' s (OPT 1) recommendations made on 3/22/2024 and carried out for Resident 1 to see a retina specialist (medical doctor who specialized in disease of the retina) and a glaucoma specialist (medical doctor who specialized in glaucoma [ eye disease that can cause vision loss and blindness]). Resident 1 was not seen by retina specialist (MD 2) until 8/1/2024 (132 days later) and was seen by the glaucoma specialist (MD 3) on 8/27/2024 (158 days later).</li> <li>2. Ensure Social Services Director (SSD 1), case management (CM 1), and licensed nurses relayed recommendations from ancillary services (diagnostic and supportive measures that help healthcare providers treat residents) to Resident 1 ' s primary physician (MD 1), obtained an order from the physician and followed through with scheduling/arranging appointments for Resident 1 to see retina and glaucoma specialists for the right eye blurred vision.</li> </ol> <p>As a result of these deficient practices Resident 1 had decreased vision in the right eye leading to right eye vision loss and becoming blind developing a depression (a mental disorder that can affect a person's feelings, thoughts, behavior, and sense of well-being. It's characterized by a low mood, loss of interest in activities) requiring medical treatment, becoming isolated (having minimal contact) from his family and loss of independence in activities of daily living ([ADLs] activities related to personal care).</p> <p>(cross reference: F684 and F745)</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptom), type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) with proliferative diabetic retinopathy (a severe stage of diabetic retinopathy that occurs when new blood vessels grow on the retina), blindness left eye, normal vision right eye, partial traumatic amputation (removal) of right foot, open wound right foot, primary open-angle glaucoma (a chronic and irreversible eye condition that causes gradual vision loss), unspecified eye- mild stage, regular astigmatism (a common and generally treatable imperfection in the curvature of the eye that causes blurred distance and near vision) right eye, and depression.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Admission Summary dated 10/26/2023, the admission summary indicated Resident 1 was admitted to the facility for Osteomyelitis (bone infection) and trans metatarsal amputation (a surgical procedure that removes part of the foot) to continue wound care and antibiotics (medication for infection). Resident 1 informed the infection preventionist nurse (IP) that his vision was impaired, and Resident 1 was requesting an optometry consult. Upon admission, Resident 1 was able to transfer with minimal assistance/ supervision.</p> <p>During a review of Resident 1 ' s physician ' s order summary, a new order was placed 10/26/2023 for eye health and vision consult, will follow up with treatment as indicated.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized screening and assessment tool) dated 11/2/2023, the MDS indicated Resident 1 had moderate cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment and had moderately impaired vision (limited vision; not able to see newspaper headlines but can identify objects). The MDS indicated it was very important for Resident 1 to choose what clothes to wear and to take care of his personal belongings. The MDS indicated Resident 1 needed set-up or clean-up assistance (staff sets up or cleans up; resident completes activity) for eating, dressing upper body, toileting, and showering.</p> <p>During a review of Resident 1 ' s care plan, a care plan for The resident has impaired visual function related to cataracts (a cloudy area that develops in the lens of the eye, causing vision loss), diabetes, disease process, at risk for complications initiated 3/20/2024 (5 months after admission). Care plan goals for Resident 1 included Resident 1 not having any acute eye problems, no decline in visual function, and Resident 1 was to maintain optimal quality of life within limitation imposed by visual function. Interventions for Resident 1 included, arranging consultations with eye care practitioner as required, and monitoring/ documenting/ reporting any signs or symptoms of acute eye problems.</p> <p>During a review of Resident 1 ' s visit summary from OPT 1 dated 3/22/2024, OPT 1 prescribed new eye medications (1. Rocklatan eye drops (used to treat high IOP) at bedtime in bilateral eyes 2. Combigan eye drops (treats high IOP) twice daily in bilateral eyes 3. Acetazolamide oral (medication used to treat high IOP) 1 tablet twice a day) as resident reported he used to take drops but had not been using them (unknown reason why). OPT 1 stressed tight compliance with medications to preserve his current vision and referral was needed to a glaucoma specialist. OPT 1 indicated at the time of evaluation 3/22/2024, Resident 1 had 20/40 (sees things at 20 feet that most people who don't need vision correction can see at 40 feet) vision in the right eye enabling the resident to see and move around on his own. OPT 1 recommended a follow up with retina specialist next available.</p> <p>During a review of Resident 1 ' s Social Services note dated 4/1/2024 written by SSD 1, the note indicated Resident 1 stated he gave the social services assistant (SSA) the phone number to schedule an appointment with his eye doctor (follow up recommended by OPT 1), SSD 1 requested that Resident 1 provided her (SSD 1) with the phone number for the eye doctor and Resident 1 responded by punching the wall on the side of the door of the social services office with a closed fist. Resident 1 was referred to psychiatric and psychology services post incident.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Social Services note dated 4/3/2024, SSA wrote I have been following up by calling the eye doctor to see about getting the code that he (Resident 1) misplaced. A review of the Social Services notes indicated there was no future follow up regarding the eye doctor appointment after this entry on 4/3/2024.</p> <p>During a review of Resident 1 ' s in-house Ophthalmology Exam/ Consult &amp; Report note dated 4/16/2024, the note indicated the goal of treatment was to maintain quality of life and preservation of vision. The note indicated Resident 1 was being followed by OPT 1 for drops and pressure control (Resident 1 was not seen again by OPT 1 after the appointment on 3/22/2024).</p> <p>During a review of Resident 1 ' s change of condition (COC) note dated 6/30/2024, Resident 1 complained of blurry vision in bilateral eyes and was seeing lights and shapes, MD 1 ordered a stat (as soon as possible) comprehensive metabolic panel (a routine blood test that measures 14 substances in your blood to evaluate your body's chemical balance and metabolism). No physician order placed for eye exam.</p> <p>During a review of Resident 1 ' s Transfer to Hospital Summary dated 6/30/2024, Resident 1 called 911 (emergency medical services) himself for blurry vision and feeling blind and he was taken to a general acute care hospital (GACH).</p> <p>During a review of Resident 1 ' s GACH Emergency Documentation dated 6/30/2024, Resident 1 was seen in the emergency department (ED) with the chief complaint of right eye vision changes since Friday (6/28/2024). Resident 1 felt as though something was stuck in his right eye but was uncertain. Resident 1 ' s eyes were irrigated, and he was diagnosed in the ED with eye irritation. The ED physician (MD 5) wrote in the Emergency documentation that he called the facility multiple times with no answer to request more information about Resident 1 ' s medication prior to discharge. Discharge instructions for Resident 1 included following up with MD 1 and an ophthalmologist and return to the ED for any worsening symptoms, diagnosis was eye irritation.</p> <p>During a review of Resident 1 ' s nurse progress notes dated 7/1/2024, the note indicated Resident 1 needed authorization to see an ophthalmologist (MD 4) and CM 1 was notified and would follow up.</p> <p>During a review of Resident 1 ' s nurse progress notes dated 7/2/2024, the secretary of MD 4 informed facility staff that MD 4 did not accept Resident 1 ' s insurance, CM 1 and SSD 1 was notified.</p> <p>During a review of Resident 1 ' s physician order summary, a new order was placed 7/8/2024 for ophthalmology consult due to status post witnessed fall from glaucoma (fall occurred 7/5/2024, per COC note dated 7/5/2024, Resident 1 was going to the restroom and tripped on something on the floor. No injuries noted).</p> <p>During a review of Resident 1 ' s nurse progress notes dated 7/9/2024, authorization was received to see MD 4 and was faxed to their office, note indicated staff was to follow up on the next business day for appointment. No information regarding follow-up documented until 7/15/2024, see COC note.</p> <p>During a review of Resident 1 ' s COC note dated 7/15/2024, Resident 1 was complaining of increased blurry vision and Resident 1 verbalized his eyesight was getting worse. The COC note indicated the writer (LVN 4) called the office of MD 4 and faxed over the authorization.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s physician ' s order summary, a new order was placed 7/16/2024 for an appointment with ophthalmologist (MD 2) on 8/1/2024 at 2 p.m.</p> <p>During a review of Resident 1 ' s Psychiatric Evaluation note dated 7/18/2024, indicated Resident 1 expressed he was stressed because I ' m going blind. His Zoloft (antidepressant medication) was increased from 50 milligram ([mg] a unit of measurement) (4/28/2024) to 100 (7/19/2024) mg by mouth daily.</p> <p>During a review of Resident 1 ' s MDS dated [DATE], the MDS indicated Resident 1 was cognitively intact and had moderate impaired vision see (see minimum data set nurse [MDSN] interview from 9/6/2024 regarding vision assessment). The MDS indicated Resident 1 needed set-up or clean-up assistance (staff sets up or cleans up; resident completes activity) for eating, dressing upper body, and toileting. The MDS indicated Resident 1 required supervision or touching assistance (staff provides verbal cues and/ or touching/ steadying as the resident completes the activity) for showering.</p> <p>During a review of Resident 1 ' s Visit Summary from the retina specialist (MD 2) on 8/1/2024, Resident 1 ' s intraocular pressure ([IOP]the pressure of the fluid inside the eye) in the Oculus [NAME] ([OD], right eye) was 29, 25 (normal IOP= between 10 and 21 millimeters of mercury (mmHg, a unit of measurement). Resident 1 received two urgent Intravitreal ([[NAME]]) injections that are used to treat a variety of retinal conditions) injections in the right eye during the appointment on 8/1/2024 and MD 2 recommended a follow up appointment in 3 weeks for pan-retinal photocoagulation ([PRP] a laser treatment that is the standard intervention for patients with proliferative diabetic neuropathy). Resident 1 received two injections in his right eye (injections: Bevacizumab 10 mg and Intravitreal NJX for diabetic retinopathy with macular edema [happens when blood vessels leak into part of the retina, causing swelling] during this visit. Resident 1 was newly diagnosed with neovascular glaucoma ([NVG] a serious type of glaucoma that can lead to blindness or vision loss) of the right eye on 8/1/2024.</p> <p>During a review of Resident 1 ' s Psychiatric Evaluation dated 8/16/2024, indicated Resident 1 expressed my eyes are concerning me. Resident 1 ' s Zoloft was increased to 150 mg (8/17/2024) daily for depression manifested by increasing feelings of hopelessness and helplessness.</p> <p>During a review of Resident 1 ' s Visit Summary from MD 2 dated 8/26/2024, MD 2 requested a glaucoma evaluation as soon as possible and recommended retina follow up, and plan for tube surgery (small flexible tube placed in eye to relieve pressure and drain fluid) versus cyclophotocoagulation ([CPC] a laser that reduces eye pressure and treats glaucoma) for the right eye. Resident 1 ' s right eye IOP on 8/26/2024 was 46.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the Visit Summary from the glaucoma specialist (MD 3) dated 8/27/2024, MD 3 indicated Resident 1 was complaining of flashing lights, watery eyes, and eye pain in the right eye. Resident 1 had IOP in bilateral eyes, but the treatment goal was to bring the IOP down below 21 for the right eye and comfort care (a type of medical care that focuses on relieving pain and other symptoms to improve the quality of life for patients) for the left eye. The visit summary indicated Resident 1 had developed new vitreous hemorrhage (VH) blood in the center of the eye) and NVG in the right eye since he was last seen by specialist (MD 2) 7/2023. The visit summary indicated Resident 1 developed new blurred vision a few weeks ago (unspecified date). MD 3 recommended to schedule [NAME] tube shunt surgery (a type of glaucoma drainage implant that's used in a surgical procedure to reduce pressure on the optic nerve and prevent vision loss) with corneal patch (a surgical procedure that can be used in conjunction with tube shunt surgery to treat glaucoma) of the right eye as soon as possible (surgery scheduled 9/10/2024).</p> <p>A review of Resident 1 ' s Physician Order dated 8/27/2024, indicated recommend right eye urgent glaucoma tube shunt surgery for Resident 1.</p> <p>A review of Resident 1 ' s Physician Order, Resident 1 was scheduled for emergency right eye tube shunt surgery with corneal patch on 9/10/2024.</p> <p>During an interview on 9/3/2024 at 2:01 p.m., Resident 1 stated he had been asking multiple staff members including the IP, SSD 1 and charge nurse (not specified) to send him out to his eye specialist (MD 2) since the day he got to the facility on [DATE]. Resident 1 stated he came to the facility with a left eye cataract and blindness, but his right eye vision was intact. Resident 1 stated he had been seeing an outside retinal specialist (MD 2) prior coming to the facility and he needed to have a follow up appointment. The resident expressed his concerns to IP, SSD 1, and charge nurse (not specified). Resident 1 stated he was not seen by an outside optometrist (OPT 1) until 3/22/2024 and OPT 1 recommended he (Resident 1) needed to see a retina specialist and glaucoma specialist, but the facility never made the appointment. Resident 1 stated, in June 2024, his right eye vision worsened, and he is now blind on both eyes. Resident 1 stated he feels very sad that he cannot see his grandkids football games and does not visit his grandkids anymore because he does not want them to see their grandpa this way (blind). Resident 1 stated he would no longer be able to see the joy on his grandkids faces when he was able to attend their games, so he would rather not go. Resident 1 expressed feeling depressed due to being blind. Resident 1 stated the psychiatrist increased his antidepressant medication Zoloft and he was able to pull himself, out of that dark place but he is still depressed. Resident 1 stated he was able to finally see MD 2 and MD 3 in August (8/1/2024 with MD 2, 8/26/2024 with MD 2, and 8/27/2024 with MD 3) and he is now scheduled for surgery to place a shunt in his eye to relieve pressure. Resident 1 stated MD 3 informed him that the surgery may or may not improve his eyesight but it was worth the try. Resident 1 stated he is so upset with the facility because he informed multiple staff members including the IP, SSD 1 and unspecified charge nurses and no one took him seriously until he got licensed vocational nurse (LVN 4) involved, and she got him an appointment rather quickly to see MD 2. Resident 1 stated the facility just does not understand, they made me blind.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/4/2024 at 9:15 a.m., Resident 1 was sitting in his wheelchair at his bedside trying to open his bedside drawer. Resident 1 was fumbling around trying to find the drawer knob and knocked his hair gel on the floor and yelled now shit, what was that. Resident 1 was unable to see the hair gel on the floor and required assistance to pick it up. Resident 1 had an electric razor in his hand and stated he was going to shave himself off memory and then he would have certified nursing assistant (CNA 1) come in and fix any spots he missed and to help him pick out clothes.</p> <p>During an interview on 9/4/2024 at 11:42 a.m., LVN 4 stated Resident 1 used to be able to see more but now he cannot see out of either eye. LVN 4 stated his eyesight got worse recently (the end of June) and she was having trouble scheduling him an appointment with MD 4 due to insurance, but it got to the point where she was calling the insurance herself to ensure authorization was obtained. LVN 4 stated she took it upon herself to get the authorization for the appointment because she was concerned for Resident 1 when he stated his eyesight was worsening and she did not feel like the authorization was getting done quick enough. LVN 4 stated she was really pushing CM 1 and SSD 1 to follow up with the authorization. LVN 4 stated Resident 1 now required more help with ADLs and needed assistance to open his meal tray when he was able to do that by himself before. LVN 4 stated Resident 1 was a younger guy and tried his best to be independent even with the worsening eyesight, but he did now require more help. LVN 4 stated Resident 1 verbalized being upset due to his eyesight, and she was unsure why the other nurses did not try harder to obtain the eye appointment for him. LVN 4 stated she called the insurance and obtained a list of physicians that they covered since they did not cover MD 4 and sometimes you have to think out of the box to try to get appointments. LVN 4 stated she put herself in the resident ' s shoes and pictured how she would feel if she was losing her eyesight and made it her goal to get Resident 1 an appointment as soon as possible (started working on appointment 7/2024). LVN 4 stated she was not sure if the appointment would have been obtained if she was not the one calling the insurance and getting authorization. LVN 4 stated maintaining vision was very important for physical well-being and decreased vision could exacerbate depression.</p> <p>During an interview on 9/4/2024 at 12:34 p.m., SSD 1 stated her role with scheduling appointments was to ensure the resident had transportation to the appointment and the nursing team was responsible for scheduling appointments. SSD 1 stated, SSA was no longer at the facility but when Resident 1 punched the wall in 4/2024, he was upset that he gave a phone number for his eye specialist to SSA to help him schedule the appointment and it wasn ' t done. SSD 1 stated she talked to SSA about that situation because the nurses were supposed to make the appointments not the SSA or SSD 1. SSD 1 stated when a doctor recommends a specialist, the order should be input right away.</p> <p>During an interview on 9/4/2024 at 12:57 p.m., CM 1 stated nursing must get the recommendations from the doctor, then nursing must put the orders and communicate with CM 1 that an appointment was needed, and authorization was required, if nursing does not communicate that an order was placed, CM 1 would not know authorization was required. CM 1 stated the meaning of next available appointment meant right away.</p> <p>During an interview on 9/5/2024 at 3 p.m., the director of nursing (DON) reviewed the Visit Summary from OPT 1 on 3/22/2024 and stated there was a recommendation for Resident 1 to see a retina and glaucoma specialist as soon as possible. The DON stated there were no orders placed after the visit on 3/22/2024 for either a retina specialist or glaucoma specialist and there were no notes in the chart informing MD 1 that these consults were requested by OPT 1. The DON stated the nurse receiving the After Visit Summaries when a Resident returned from an appointment was to review the document in its entirety to ensure no recommendations were missed.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/5/2024 at 8:43 a.m., the Retina Specialist (MD 2) stated he began seeing Resident 1 in April of 2023 for diabetic retinopathy (a complication of diabetes that affects the eyes) and Resident 1 was receiving injections and laser treatment (medical procedure to treat some types of glaucoma) to stop bleeding in the eyes. MD 2 stated he last saw Resident 1 in July of 2023 and Resident 1 was blind on the left eye, but he had 20/15 vision in the right eye. MD 2 stated there was a large gap in seeing Resident 1 and when Resident 1 was seen on 8/1/2024 there was bleeding in the right eye and Resident 1 had lost his right eye vision. MD 2 stated Resident 1 does have glaucoma and advanced diabetic retinopathy but there are treatments such as medications, injections in the eye, and laser treatments that can stop the bleeding in the eye, so theoretically, if Resident 1 was seen sooner, the eyesight in the right eye could have been preserved and the progression of the disease slowed down.</p> <p>During an interview on 9/5/2024 at 9:36 a.m., during a follow up interview with Resident 1, Resident 1 stated I was angry that I felt like no one was doing anything, and then in March they sent me to an outside optometrist (OPT 1), and she wanted me to see the retina specialist. The SSD 1 was supposed to set him up with the retina specialist but they acted like they couldn ' t find the number. Resident 1 stated he was getting so mad at the facility because he didn ' t want his vision to get worse so he would yell at them sometimes. Resident 1 stated he would much rather be deaf than blind because you need your eyes for everything. Resident 1 stated that on 6/30/2024, he still had not seen any specialist for his eyes and he started getting extreme pain in his eyes and his vision was increasingly blurred. He felt as though the facility was not taking him seriously, so he called 911 and when he went to the GACH, all they did was wash his eye with water and told him he needed to see ophthalmology and sent him back to the facility, but they did not know about his eye history. Resident 1 stated, a few days went by and his eyes started watering really bad and got even more blurry so he got pissed off again and went off on them, then the DON met with Resident 1 and SSD 1 and he voiced that his vision was getting worse and he was pissed because he had been telling the staff that he needed to see the specialist and no one was taking him seriously and now he was going blind. Resident 1 stated he still was not getting anywhere with the appointments until LVN 4 got involved in mid-July, when LVN 4 obtained an appointment for him with MD 2. Resident 1 stated that he can no longer see his clothes to pick them out, he can sometimes feel in his closet to feel what to pick but usually he asks CNA 1 to help him pick something. Resident 1 stated his appearance was very important to him and he always took pride in what he was wearing and hopes he still looks good. Resident 1 stated This is so embarrassing for me; I can ' t even see what I look like so I would rather not see my family/ grandkids until I get this figured out. Resident 1 stated, pray for me that these surgeries help me, I am still young. Resident 1 stated most of his behavior problems were because of his eyesight and the facility referred him to psychology because of that. Resident 1 stated the facility was not taking me seriously, and in the future, they should take patients word for it and not just ignore us (Resident 1 was taking about his need for retina specialist and his increased blurry vision).</p> <p>During an interview on 9/5/2024 at 12:02 p.m., the MDSN stated a resident would require an impaired vision care plan when admitted if the resident had issues with eyesight or the potential for decreased eyesight. The MDSN stated a vision care plan was important to ensure the resident was going to all appointments needed for the eyes and to ensure all the resident ' s needs were met. The MDSN stated Resident 1 ' s MDS on 7/31/2024 was coded as moderately impaired because he could see but it was not clear. The MDSN stated Resident 1 just complained about complete vision loss recently, so it was not yet reflected on the MDS assessment.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/5/2024 at 1:50 p.m., CNA 1 stated Resident 1 began complaining about increased vision deterioration about 2 to 3 months ago, but before that, Resident 1 was able to see very well and was very independent with all his activities of daily living (ADLs). CNA 1 stated Resident 1 cannot see now so he (CNA 1) must set up the resident ' s meal tray, open everything on his meal tray, inform Resident 1 whatever he will be having on his meal tray, inform him where his water is so he can stay hydrated. CNA1 stated Resident 1 also needs help with dressing now as the resident puts his clothing on backwards. CNA 1 stated Resident 1 is very young and wishes to remain independent so he (CNA 1) will just stand by and intervene only but requires a lot of assistance now because he cannot see as he did before. CNA 1 stated Resident 1 became very depressed due to loss of eyesight. CNA 1 stated Resident 1 was usually a very social man but when he started going blind a few months ago, he was just sitting in his room and did not want to talk to anyone.</p> <p>During an interview on 9/5/2024 at 2:33 p.m. SSD 1 stated there was no documentation found in the chart that herself or the SSA followed up with the retina specialist appointment after 4/3/2024 and Resident 1 did not see the retina specialist (MD 2) until 8/1/2024.</p> <p>During an interview on 9/5/2024 at 4:38 p.m., the DON stated Resident 1 was not seen by MD 2 until 8/1/2024 after referral was requested by OPT 1 on 3/22/2024. The DON stated it was the facility policy to document any conversations and follow ups regarding patient appointments in the resident ' s chart, but he could not find any follow up documentation regarding the specialist eye appointments until 7/2024. The DON stated if something was not documented, it was not done. The DON stated it was very important to maintain eyesight because eyesight was needed to care for oneself.</p> <p>During an interview on 9/6/2024 at 10:10 a.m., registered nurse (RN 1) stated she was the nurse that received the Visit Summary when Resident 1 returned from his eye appointment with OPT 1 on 3/22/2024. RN 1 stated it was facility policy to review the whole packet that is brought in after a resident returned from an appointment to ensure nothing was missed. RN 1 reviewed the after-visit summary from OPT 1 on 3/22/2024 and physician ' s orders for Resident 1 and stated, OPT 1 was requesting for Resident 1 to see a glaucoma specialist and retina specialist as soon as possible but there were no orders entered for the referrals after the visit. RN 1 stated CM 1 would not know that authorization was needed for a specialist appointment unless there was a physician order, which there wasn ' t. RN 1 stated she was new to the facility in 3/2024 and was learning many different things, so she was sorry if she missed the recommendation for the specialist. RN 1 does not remember reviewing the whole document from OPT 1 but did remember placing an order for the new eye medications prescribed by OPT 1. RN 1 stated the recommendation for a glaucoma specialist and retina specialist was missed.</p> <p>During an interview on 9/6/2024 at 12:10 p.m., SSD 1 stated she followed up on recommendations done by ancillary services done in house but did not follow up on the recommendations made by ancillary services outside the facility, nursing did. SSD 1 stated it was part of her job description to arrange ancillary services, but she was only checking in house ancillaries and not reviewing notes from outside ancillaries and their recommendations to follow up on unless nursing placed an order and SSD 1 needed to arrange transportation. SSD 1 stated if nursing did not input the orders, SSD 1 would not know about recommended referrals. SSD 1 stated there was no facility process to confirm what services the resident required when they came back from outside ancillary services. SSD 1 stated if nursing missed a referral requested by the outside physician, no one was coming behind the nurses to review and check the recommendations to ensure they were entered.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/6/2024 at 1:30 p.m., the MDSN stated she visited and assessed the vision of Resident 1 that morning (9/6/2024) and he was only able to see shadows out of the right eye. The MDSN stated the next comprehensive MDS assessment for Resident 1 would be coded as highly impaired for vision. The MDSN stated she placed an order for Resident 1 on 9/6/2024 to monitor vision every shift to ensure his vision did not decline. The MDSN stated the care plan initiated 3/20/2024 stated o monitor vision every shift but there was no order in the resident ' s chart until she entered the order that day.</p> <p>During an interview on 9/6/2024 at 2:50 p.m., MD 3 stated he was the glaucoma specialist seeing Resident 1 and stated Resident 1 needed an urgent shunt placement in his right eye to relieve pressure. MD 3 stated, Resident 1, most likely would not regain vision in his right eye, but the surgery would help maintain any vision he had now and would allow him to receive the retina treatments required. MD 3 stated, MD 2 was not able to do any treatments on the retina at this time because there was lots of fluid built up in the right eye and the retina was not visible. MD 3 stated there was a high likelihood that Resident 1 ' s right eyesight could have been preserved if he was receiving the treatments he needed when they were recommended. MD 3 stated they would not be in the position they were in with Resident 1 ' s eyesight if he had received treatment sooner when he still had eyesight in the right eye.</p> <p>During a review of the facility ' s Social Services Coordinator (SSD) job description undated, indicated the SSD was to arrange ancillary services that have been determined necessary to maintain resident ' s concrete needs.</p> <p>During a review of the facility ' s Policy and Procedure (P/P) titled Diabetic Care dated 1/1/2012, the P/P indicated the interdisciplinary team (IDT) was to ensure the care plan addressed the resident ' s diabetes, goals, and interventions and regular eye care exam education was to be provided to the resident.</p> <p>During a review of the facility ' s P/P titled Referrals to Outside Services dated 12/1/2013, the P/P indicated the SSD was to coordinate the referral of residents to outside agencies to fulfill resident ' s needs for services not offered by the facility. The P/P indicated the SSD was responsible for locating agencies that met the needs of the resident and for clinical services, a nursing designee was to assist the SSD in locating a provider. Referrals for medical services were only to be made pursuant to a physician ' s order. The SSD or his/ her designee was to coordinate with nursing staff to ensure that the attending physician ' s order and referral to outside provider was documented in the resident ' s medical record.</p>		