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 10/04/2024
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 1 and Resident 2) were not inappropriately touched; Resident 1 on her buttocks twice by a male resident (Resident 3), when Resident 3 and Resident 2 were left unattended on the facility's patio on 10/1/2024, and when Resident 3 was not closely monitored following his inappropriate sexual behavior with Resident 2 on the previous day (10/1/2024), leading to Resident 3 touching Resident 2 on her left thigh and left breast on 10/2/2024. This deficient practice resulted in Resident 1 and Resident 2 feeling unprotected, uncomfortable and/or disrespected when they were touched inappropriately by Resident 3. This deficient practice and had the potential for inappropriate sexual contact to continue with other residents. Findings: During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis including unspecified mood disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind and feeling), schizophrenia (a mental disorder characterized by disruption in one's thoughts processes, perception, emotional responsiveness and social interactions) and depression (a disorder that presents constant feelings of sadness and loss of interest, which stops the person from doing normal activities of daily living). During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment and tool) dated 7/25/2024, the MDS indicated Resident 3 was able make decisions that were reasonable and consistent. During a review of Resident 3's Change of Condition (COC) dated 10/1/2024 and timed at 3:58 p.m., the COC indicated on 10/1/2024 at 3:05 p.m., a female resident (Resident 1) reported that Resident 3 touched her inappropriately. During a review of Resident 3's Care Plan, titled Female Peer Claimed Resident 3 Touched her Inappropriately dated 10/1/2024, the Care Plan indicated a goal for Resident 3 was to have no further episodes of touching other peers inappropriately with interventions to monitor Resident 3's increased episodes of inappropriate sexual behavior, promptly notify Resident 1's primary physician and encourage Resident 3's attendance at daily activities to divert his attention. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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 10/04/2024
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's COC dated 10/2/2024 timed at 3:31 p.m., the COC indicated at around 10 a. m., a female resident (Resident 2) reported to a charge nurse (Licensed Vocational Nurse 1 [LVN 1]) that Resident 3 inappropriately touched her breasts. During a review of Resident 3's Care Plan, titled Resident Has Another Episode of Inappropriate Sexual Behavior dated 10/2/2023, the Care Plan indicated a goal for Resident 3 was to have no further episodes of inappropriate behavior with interventions to continuously monitor Resident 3 for inappropriate sexual behavior, report to Resident 3's primary physician, provide one-on-one supervision to Resident 1 until further orders, and redirect Resident 3's attention if observed having inappropriate sexual behavior. During an interview on 10/3/2024 at 1:14 p.m., Resident 2 stated she and Resident 3 were on the facility's patio by themselves yesterday morning (10/2/2024, unsure of the time) talking to each other when Resident 3 touched her left thigh and left breast after telling her (Resident 2) that his (Resident 3) wife passed away and he (Resident 3) was looking for a friend. Resident 2 stated she was uncomfortable, and she left the patio. Resident 2 stated she reported the incident to LVN 1 and Certified Nursing Assistant 1 (CNA 1). During a telephone interview on 10/3/2024 at 1:35 p.m., Resident 1 stated she felt disrespected when Resident 3 ran his fingers in between her buttocks two times and stated this horrible experience would not have happened to her, if there was a facility staff member who consistently monitored the residents who were on the patio. During an interview on 10/3/2024 at 3:11 p.m., LVN 1 stated, on 10/1/2024 around 9 a.m., Resident 2 reported to her that there was a guy (Resident 3) who was on the patio who had a lot of money in his wallet. LVN 1 stated Resident 2 told her she (Resident 2) asked Resident 3 for a dollar to buy her a sods, he gave her the dollar then touched her breast and thigh. LVN 1 stated Resident 2 told her Resident 3 made her uncomfortable when he did that. LVN 1 stated it was the responsibility of the nursing staff to monitor Resident 3's whereabouts closely following the first reported sexual inappropriateness involving Resident 1 so there would be no repeated incidents with any other resident. During an interview on 10/3/2024 at 3:31 p.m., LVN 2 stated on 10/1/2024 during the 3 p.m. to 11 p.m. shift, she notified Resident 3's physician about Resident 3's inappropriate sexual behavior with Resident 1 and Resident 3's physician gave orders to monitor Resident 3's inappropriate sexual behavior. LVN 2 stated it was expected that the nursing staff should have monitored Resident 3 closely to prevent sexual inappropriate behavior with by Resident 3 with other residents. During an interview on 10/3/2024 at 4:09 p.m., Registered Nurse Supervisor 1 (RNS 1) stated the nursing staff should have implemented one-on-one supervision for Resident 3 after the first allegation of inappropriate sexual behavior with Resident 1 on 10/1/2024 because all the residents in the facility should be free from any form of mistreatment, treated with respect and dignity and must be protected continuously to feel/be safe in their environment. During an interview on 10/4/2024 at 12:02 p.m., the Director of Nursing Services (DON) stated it was the responsibility of the nursing staff to implement the residents' plan of care and the facility's abuse prevention protocols to prevent abuse and/or mistreatment to the residents. The DON stated the facility is the residents' home, and all residents must feel safe in their environment. (continued on next page)

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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Cove Post Acute	1730 Grand Ave Long Beach, CA 90804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P/P) titled Abuse Prevention and Management revised 5/30/2024, the P/P indicated the facility does not condone any form of resident abuse and/or mistreatment such as sexual abuse which is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault.

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NAME OF PROVIDER OR SUPPLIER Coral Cove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1730 Grand Ave Long Beach, CA 90804	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3), who was transferred to a General Acute Care Hospital's (GACH) emergency room (ER) after two episodes of inappropriately touching two female residents, was readmitted to the facility after the GACH's ER evaluation was completed, and Resident 3 was deemed appropriate for transfer back to the facility. This deficient practice resulted in Resident 3's unnecessary and extended stay in the GACH's ER (as of 10-21-2024 Resident 3 was still at the GACH, 17 days) and had the potential for Resident 3's continued displacement from his residence at the facility. Findings: During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis including unspecified mood disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind and feeling), schizophrenia (a mental disorder characterized by disruption in one's thoughts processes, perception, emotional responsiveness and social interactions) and depression (a disorder that presents constant feelings of sadness and loss of interest, which stops the person from doing normal activities of daily living). During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment and tool) dated 7/25/2024, the MDS indicated Resident 3 was able make decisions that were reasonable and consistent. During a review of Resident 3's Change of Condition (COC) dated 10/1/2024 and timed at 3:58 p.m., the COC indicated on 10/1/2024 at 3:05 p.m., a female resident (Resident 1) reported that Resident 3 touched her inappropriately. During a review of Resident 3's COC dated 10/2/2024 timed at 3:31 p.m., the COC indicated at around 10 a.m., a female resident (Resident 2) reported to a charge nurse (Licensed Vocational Nurse 1 [LVN 1]) that Resident 3 inappropriately touched her breasts. During a review of Resident 3's Order Summary (Physician's Order) dated 10/3/2024, the Physician's Order indicated to transfer Resident 3 to the GACH for medical clearance and then to admit Resident 3 to the psychiatric unit for behavior management due to inappropriate sexual behavior with two female residents (Resident 1 and Resident 2). During a review of Resident 3's Nursing Progress Notes dated 10/3/2024 and timed at 3:24 a.m., the Nursing Progress Notes indicated Resident 3 was transferred to the GACH at 2:30 a.m., on 10/3/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Social Services Progress Notes dated 10/4/2024 and timed at 11:58 a.m., the Social Services Progress Notes indicated the Social Services Assistant (SSA) called Resident 1's family member (FM 1) and informed her that Resident 3 was not welcome back at the facility because the two female residents (Resident 1 and Resident 2) could be triggered emotionally by his (Resident 3) presence. During a telephone interview on 10/4/2024 at 8 a.m., the Complainant stated Resident 3 was still in the GACH's ER although he had been medically cleared to go back to the facility since 10/3/2024. The complainant stated she called the facility on 10/3/2024 at 4 a.m. and spoke to a male staff (name unknown) who told her Resident 3 would not be able to return to the facility because of multiple allegations of sexual abuse from multiple residents. During an interview on 10/4/2024 at 12:48 p.m., the SSA stated the facility could not readmit Resident 3 to the facility because Resident 2 was filing charges against Resident 3. During an interview on 10/4/2024 at 12:02 p.m., the Director of Nurses (DON) stated she did not receive a call from the GACH on 10/3/2024 about Resident 3, however Resident 3 was their client at the facility and the facility would readmit him and provide care and services for if there was no pending case against him. During a review of the facility's Policy and Procedure (P/P), titled, Bed Hold dated 7/2017, the P/P indicated upon admission, the facility informs the resident/or representative in writing of the facility's bed hold policy and how to exercise the right to a bed hold. The facility notifies the resident and/or representative, in writing, of the bed hold option any time the residents' transfers to an acute care hospital or request therapeutic leave. When the resident or his/her representative provides notice within 24 hours of transfer that the resident elects his/her right to hold the bed, the facility keeps that bed available for seven days. If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility will complete a Notice of Transfer and Discharge document once the updated information becomes available. During a review of the facility's P/P, titled, Notice of Proposed Transfer and discharge date ,d+[DATE], the P/P indicated when a transfer or discharge is initiated b the facility, the facility will provide the resident, responsible party, and the Ombudsman with a Notice of Transfer and Discharge 30 days prior to the transfer or discharge unless the following exceptions apply: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, the resident's health has improved to allow a more immediate transfer or discharge, the resident's urgent medical needs cannot be met in the facility and requires immediate transfer, and the health of the individual in the facility would otherwise be endangered. In these cases, the notice will be given as son as practicable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 3) was closely monitored and supervised, following an allegation by a female resident (Resident 1) that she was inappropriately touched by Resident 3 on 10/1/2024. This deficient practice resulted in Resident 3 inappropriately touching another female resident (Resident 2) on 10/2/2024 at 10 a.m. This deficient practice had the potential for Resident 3 to continue his behavior of inappropriately touching other residents. Findings: During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis including unspecified mood disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind and feeling), schizophrenia (a mental disorder characterized by disruption in one's thoughts processes, perception, emotional responsiveness and social interactions) and depression (a disorder that presents constant feelings of sadness and loss of interest, which stops the person from doing normal activities of daily living). During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment and tool) dated 7/25/2024, the MDS indicated Resident 3 was able make decisions that were reasonable and consistent. During a review of Resident 3's Change of Condition (COC) dated 10/1/2024 and timed at 3:58 p.m., the COC indicated on 10/1/2024 at 3:05 p.m., a female resident (Resident 1) reported that Resident 3 touched her inappropriately. During a review of Resident 3's Care Plan, titled Female Peer Claimed Resident 3 Touched her Inappropriately dated 10/1/2024, the Care Plan indicated a goal for Resident 3 was to have no further episodes of touching other peers inappropriately with interventions to monitor Resident 3's increased episodes of inappropriate sexual behavior, promptly notify Resident 1's primary physician and encourage Resident 3's attendance at daily activities to divert his attention. During a review of Resident 3's COC dated 10/2/2024 timed at 3:31 p.m., the COC indicated at around 10 a. m., a female resident (Resident 2) reported to a charge nurse (Licensed Vocational Nurse 1 [LVN 1]) that Resident 3 inappropriately touched her breasts. During a review of Resident 3's Care Plan, titled Resident Has Another Episode of Inappropriate Sexual Behavior dated 10/2/2023, the Care Plan indicated a goal for Resident 3 was to have no further episodes of inappropriate behavior with interventions to continuously monitor Resident 3 for inappropriate sexual behavior, report to Resident 3's primary physician, provide one-on-one supervision to Resident 1 until further orders, and redirect Resident 3's attention if observed having inappropriate sexual behavior. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Coral Cove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1730 Grand Ave Long Beach, CA 90804	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/2024 at 1:14 p.m., Resident 2 stated she and Resident 3 were on the facility's patio by themselves yesterday morning (10/2/2024, unsure of the time) talking to each other when Resident 3 touched her left thigh and left breast after telling her (Resident 2) that his (Resident 3) wife passed away and he (Resident 3) was looking for a friend. Resident 2 stated she was uncomfortable, and she left the patio. Resident 2 stated she reported the incident to LVN 1 and Certified Nursing Assistant 1 (CNA 1). During a telephone interview on 10/3/2024 at 1:35 p.m., Resident 1 stated she felt disrespected when Resident 3 ran his fingers in between her buttocks two times and stated this horrible experience would not have happened to her, if there was a facility staff member who consistently monitored the residents who were on the patio. During an interview on 10/3/2024 at 3:11 p.m., LVN 1 stated, on 10/1/2024 around 9 a.m., Resident 2 reported to her that there was a guy (Resident 3) who was on the patio who had a lot of money in his wallet. LVN 1 stated Resident 2 told her she (Resident 2) asked Resident 3 for a dollar to buy her a sods, he gave her the dollar then touched her breast and thigh. LVN 1 stated Resident 2 told her Resident 3 made her uncomfortable when he did that. LVN 1 stated it was the responsibility of the nursing staff to monitor Resident 3's whereabouts closely following the first reported sexual inappropriateness involving Resident 1 so there would be no repeated incidents with any other resident. During an interview on 10/3/2024 at 3:31 p.m., LVN 2 stated on 10/1/2024 during the 3 p.m. to 11 p.m. shift, she notified Resident 3's physician about Resident 3's inappropriate sexual behavior with Resident 1 and Resident 3's physician gave orders to monitor Resident 3's inappropriate sexual behavior. LVN 2 stated it was expected that the nursing staff should have monitored Resident 3 closely to prevent sexual inappropriate behavior with by Resident 3 with other residents. During an interview on 10/3/2024 at 4:09 p.m., Registered Nurse Supervisor 1 (RNS 1) stated the nursing staff should have implemented one-on-one supervision for Resident 3 after the first allegation of inappropriate sexual behavior with Resident 1 on 10/1/2024 because all the residents in the facility should be free from any form of mistreatment, treated with respect and dignity and must be protected continuously to feel/be safe in their environment. During an interview on 10/4/2024 at 12:02 p.m., the Director of Nursing Services (DON) stated it was the responsibility of the nursing staff to implement the residents' plan of care and the facility's abuse prevention protocols to prevent abuse and/or mistreatment to the residents. The DON stated the facility is the residents' home, and all residents must feel safe in their environment. During a review of the facility's Policy and Procedure (P/P) titled Resident Safety revised 4/15/2021, the P/P indicated the facility nursing service personnel shall provide the residents a safe environment and must observe the safety and well-being of the residents by performing a Resident Check at least every 2 hours around the clock and more frequently depending on the residents' person-centered plan of care. During a review of the facility's P/P titled Abuse Prevention and Management revised 5/30/2024, the P/P indicated the facility does not condone any form of resident abuse and/or mistreatment such as sexual abuse which is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault.