

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  10/22/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28851</p> <p>Based on interviews and record review, the facility failed to ensure there was a facility policy developed and implemented to verify whether the prescribers of residents ' antipsychotic (medications that treat symptoms that happen with schizophrenia and other conditions that involve psychosis) medications had obtained informed consents prior to administration, for two (2) of 3 sampled residents (Residents 1 and 3).</p> <p>These deficient practices had the potentials of unnecessary medications and residents ' rights issue.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission record, the admission record indicated the resident was originally admitted on [DATE] and recently readmitted on [DATE]. Resident 1 ' s admission diagnoses included urinary tract infection, psychosis (a set of symptoms that affect the mind and make it difficult to distinguish reality from what is not real), and diabetes (high blood sugar).</p> <p>During a review of Resident 1 ' s physician's order dated 9/18/2024 at 10:30 AM, ordered by Physician 1, the physicians order indicated quetiapine 100 milligrams (mg a unit of measure of mass) give 1 tablet by mouth at bedtime for schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors) manifested by constantly calling 911.</p> <p>During a review of Resident 1 ' s physician's order dated 9/27/2024 at 4:34 PM, ordered by Physician 1, the physician's order indicated quetiapine 100 mg give 1 tablet by mouth at bedtime for schizophrenia manifested by constantly calling 911.</p> <p>During a review of the facility policy and procedures (P&amp;P), titled Behavior/Psychoactive Medication Management (dated 6/4/2024), the P&amp;P indicated .Facility must obtain a resident ' s written informed consent for treatment using psychotherapeutic drugs and consent renewal every 6 (six) months .</p> <p>During an interview on 10/22/2024 at 3:55 PM with the administrator (ADM), the ADM stated there was no other facility policy for informed consent, but the aforementioned psychoactive medication management policy, Behavior/Psychoactive Medication management</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview on 10/22/2024 at 4:14 PM of Resident 1 ' s Informed Consent Documentation for Seroquel 100 mg (dated 9/18/2024) with the assistant director of nursing (ADON), the ADON stated the medical provider ' s name on the informed consent was the psychiatrist (PSYCH 1 - a physician that specializes is diagnosing and treating mental illness) and the prescriber for Resident ' s Seroquel was resident ' s attending physician (Physician 1). The ADON stated PSYCH 1 obtained the consent and Physician 1 was the prescriber. A concurrent review of Resident 1 ' s informed consents dated 9/10/24 and 9/27/2024 also indicated the prescriber did not obtain informed consent from Resident 1.</p> <p>During a review of Resident 3 ' s physician's order dated 7/11/2024 at 12:34 AM, ordered by Physician 2, the physican's order indicated quetiapine 400 mg give 1 tablet by mouth at bedtime for schizophrenia manifested by Auditory Hallucination (hearing voices or noises that do not exist in reality) as evidenced by hearing voices in his head. The order indicated that informed consent was obtained and verified by medical doctor (MD).</p> <p>During a review of Resident 3 ' s Informed Consent Documentation for quetiapine 400 mg (dated 7/11/2024), the documentation indicated the medical provider was a psychiatrist (Psych 2), and not Physician 2.</p> <p>On 10/22/2024 at 4:38 PM during an interview, the ADM confirmed the information on the aforementioned consents indicated the prescribers did not obtain the consents from the residents.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28851</p> <p>Based on interviews and record review, the facility failed to ensure there a diagnosis for the use of an antipsychotic medication was consistent in one (1) of 4 sampled residents (Resident 1).</p> <p>These deficient practices had the potentials of unnecessary medications.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission record, the admission record indicated the resident was originally admitted on [DATE] and recently readmitted on [DATE]. Resident 1 ' s admission diagnoses included urinary tract infection (an infection that occurs anywhere within the urinary system), psychosis (a set of symptoms that affect the mind and make it difficult to distinguish reality from what is not real), and diabetes (high blood sugar).</p> <p>During a review of Resident 1 ' s psychiatric (a branch of medicine that specializes in the diagnosis and treatment of mental illness) evaluation notes, dated 7/25/2024 and 9/13/2024, the evaluation notes indicated the assessed diagnoses were bipolar (a mental illness that causes extreme mood swings, affecting a person's energy, activity levels, and concentration, that can make it difficult to perform daily tasks) and generalized anxiety (a feeling of fear, dread or uneasiness) disorder.</p> <p>During a review of Resident 1 ' s physician's order dated 9/10/2024 at 4:34 PM, ordered by a nurse practitioner (NP 1), the order indicated quetiapine (generic for Seroquel, an antipsychotic to treat certain behavioral and/or mental conditions) 100 milligrams (mg, an unit to measure mass) give 1 tablet by mouth at bedtime for bipolar disorder manifested by labile (rapid and exaggerated changes) mood.</p> <p>During a review of Resident 1 ' s physician's order dated 9/18/2024 at 10:30 AM, ordered by Physician 1, the physician's order indicated quetiapine 100 mg give 1 tablet by mouth at bedtime for schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors) manifested by constantly calling 911. There was no physician note to indicate evidence to support changing the diagnose from bipolar to schizophrenia.</p> <p>During a review Resident 1 ' s inpatient discharge instruction from an acute psychiatric hospital dated 9/27/2024, the discharge insturctions indicated the discharge diagnosis was bipolar 1 disorder and psychotic (when a person loses touch with reality) symptoms.</p> <p>During a review of Resident 1 ' s physician's order dated 9/27/2024 at 4:34 PM, ordered by Physician 1, the order indicated quetiapine 100 mg give 1 tablet by mouth at bedtime for schizophrenia manifested by constantly calling 911.</p> <p>(continued on next page)</p>		

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<p>F 0758</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 psychiatric evaluation notes dated 10/15/2024, the nurse practitioner who conducted the psychiatric visit indicated the diagnoses as schizoaffective (a rare mental illness that occurs when a person has symptoms of both schizophrenia [(a chronic mental illness that affects a person ' s thoughts, feelings, and behaviors] and a mood disorder) disorder bipolar type and anxiety.</p> <p>During a review of Resident 1 ' s physician's order dated 10/18/2024 at 3:57 PM, ordered by Physician 1, the order indicated an increase in dose of quetiapine 150 mg extended release oral tablet to be given by mouth at bedtime for schizophrenia manifested by anger outburst as evidenced by throwing stuff.</p> <p>On 10/22/2024 at 3:25 PM during an interview and a concurrent review of the aforementioned documents, the administrator (ADM) confirmed the diagnosis on Resident 1 ' s health records did not match Resident 1 ' s antipsychotic medication orders.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled Behavior/Psychoactive Medication Management dated 6/4/2024, the P&amp;P indicated . Antipsychotic medications are to be used only to treat specific mental health diagnoses .</p>		