Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055077	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Cove Post Acute	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 4) was not restrained, by pushing the right side of her bed against a wall, with pillows on the left side of her bed tucked underneath her sheets, thus preventing Resident 4 from getting up from bed or moving in bed. This deficient practice resulted in Resident 4's inability to get out of bed and restricted her movements in bed. This deficient practice had the potential to result in the further decline in her mobility and function and an undignified existence. Findings: During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including delirium (a serious change in the mental abilities of a person and results to confused thinking and lack of awareness of their surroundings) and a recent fall (10/2/2024). During a review of Resident 4's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated Resident 4 was understood and able to be understood by others. The MDS indicated Resident 4 was dependent on staff and required two or more persons to assist in the completion of her activities of daily living ([ADLS] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and did not use any form of restraints. During a review of Resident 4's History and Physical (H&P) dated 9/17/2024, the (H&P) indicated Resident 4 was alert to self and did not have the capacity to give consent. During a review of Resident 4's Change in Condition (COC) Evaluation, dated 10//2024 and timed at 6:31 p. m., the COC indicated on 10/2/2024, Resident 4 was seen lying on the floor, on the left side of her bed. During a review of Resident 4's clinical record, the clinical record indicated there was no restraint assessment conducted nor was there a physician's order for Resident 4 to be restrained. (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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/25/2024 at 12 p.m., Resident 4 was observed asleep in bed, the right side of her bed was pushed up against a wall and the left side of her bed had pillows tucked underneath her bedsheet. Resident 4 woke up when greeted and upon hearing her name attempted to sit up but was unsuccessful because the pillows that were tucked underneath the left side of Resident 4's bedsheet prevented her from moving. During an interview on 10/25/2024 at 12:32 p.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 4 was always quick to get up from bed unassisted, and because of that she had a low bed in place and a floor mat on the left side of her bed. CNA 1 stated, Resident 4's bed was against the wall with pillows tucked underneath her bed sheet when he arrived at work. During an interview on 10/25/2024 at 12:48 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 4 was a fall risk, but her bed should not be pushed up against the wall, and pillows should not be tucked underneath her sheets, because doing so limited Resident 4's movement During an interview on 10/25/2024 at 1:26 p.m., Registered Nurse Supervisor 1 (RNS 1) stated the nursing staff must have placed the pillows underneath Resident 4's sheets and pushed her bed against the wall to reinforce Resident 4's fall precautions; however, those measures restrained the movements of Resident 4 and were not allowed. During an interview on 10/25/2024 at 2:26 p.m., Minimum Data Set Nurse (MDS) stated the facility do not allow any form of physical restraints to be applied on or around the residents, at any given time. MDS stated there was never an order from the primary physician of Resident 4 nor a signed consent from Resident 4's conservator. MDS stated Resident 4 could incur an injury with a bed against the wall and could restrict her movements that can ultimately alter her (Resident 4) mobility and function causing a decline in her health status. During an interview on 10/25/2024 at 3:12 p.m., the Administrator (ADM) stated placing Resident 4's bed against a wall was a life safety concern and limited Resident 4's freedom to move and to be comfortable. The ADM stated it was the responsibility of all staff to ensure all residents were free from any form of restraints. During a review of the facility's Policy and Procedure (P/P) titled NP115 Restraints revised 1/25/2024, the P/P indicated the facility shall honor the residents' right to be free from any form of restraints that were imposed for reasons other than that of treatment of the resident's medical symptoms. The P/P indicated restraints require a physician order and an informed consent before initiation and were used as a last resort only when deemed necessary by the interdisciplinary team, and in accordance with the resident's assessment and plan of care.

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45537

Based on interview and record review, the facility failed to ensure that a care plan with a goal to minimize falls and to decrease significant injuries as a result of any the falls by placing a bed at the lowest position with floor mats on both sides of the bed, for one of three sampled residents (Resident 1) was followed. Resident 1 was found kneeling on the floor by the left side of her bed, holding onto the bed's siderail with the bed in a high position and no floor mats on the floor beside Resident 1's bed. The facility failed to:

Ensure Resident 1 had her bed in the lowest position with floor mat on the left side of Resident 1's bed, based on Resident 1's Care Plan dated 3/20/2022.

This deficient practice resulted in Resident 1 sustaining a fracture (a break in the bone) to her T11 and T12 thoracic bones (the part of the spine between the neck and the abdomen that make up vertebrae [a series of small bones forming the backbone] from T1 through T12 and mostly protect the heart and lungs), and fractures of her right tibia ([shin] the inner and usually larger of the two bones between the knee and the ankle) and fibula ([calf bone] the outer and usually smaller of the two bones between the knee and the ankle).

Findings:

During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including glaucoma (an eye disease that can cause vision loss and blindness), legal blindness, and dementia (a progressive state of decline in mental abilities),

During a review of Resident 1's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 8/15/2024, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent. The MDS indicated Resident 1's vision was severely impaired.

During a review of Resident 1's History and Physical (H&P) dated 9/2/2024, the H&P indicated Resident 1 also had diagnoses that included osteoarthritis (a degenerative joint disease in which the tissue in the joint break down over time), and encephalopathy (a change in how the brain works due to an underlying condition and causes confusion, memory loss and loss of consciousness).

During a review of Resident 1's Fall Risk Assessment, dated on 9/2/2024 and timed at 10:23 a.m., the Fall Risk Assessment indicated a score of 15. A score of 10 or more indicated a high risk for falls.

During a review of Resident 1's Order Summary Report (Physician's Order), dated 10/2024, the Physician's Order indicated the following orders:

1. On 3/20/2022 Resident 1 may have bilateral (both) floor mats (a cushioned floor pad designed to help prevent injury should a person fall) every shift.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	2. On 3/20/2022 keep Resident 1's bed at the lowest position every shift. During a review of Resident 1's untitled Care Plan, dated 3/20/2022, the Care Plan indicated Resident 1 was at risk for falls/injury related to her cognitive impairment (a condition where there are problems of the person's ability to think, learn, remember, use judgement, and make decisions), encephalopathy, chronic obstructive pulmonary disease ([COPD] a lung disease that causes breathing problems and restricted airflow), legal blindness, dementia, fibromyalgia (a chronic condition that causes widespread pain and tenderness in the body), and age-related debility (a state of general weakness or feebleness that may be a result or an outcome of one or more medical conditions). The Care Plan indicated a goal to minimize Resident 1's risk of falls and decrease significant injuries as a result of the falls. The Care Plan's interventions included ensuring Resident 1's bed was kept at the lowest position with floor mats on both sides of Resident 1's bed. During a review of Resident 1's Change in Condition (COC) form, dated 10/10/2024 and timed at 2:24 a.m., the COC form indicated Resident 1 had a fall incident with left leg pain (later determined at the GACH to be the right leg/knee) level rated 10 out of 10 on a pain scale of zero to 10 (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain), blood pressure (BP) of 230/159 millimeters of mercury (mmHg, normal BP is 120/80), heart rate (HR) of 129 beats per minute (bpm, normal HR is 60-100 bpm), and respiratory rate (RR) of 22 breaths per minute (normal range is 12-18 breaths per minute). During a review of Resident 1's Nursing Progress Notes dated 10/10/2024 and timed at 4:22 a.m., the Nursing Progress Note indicated Resident 1 was found kneeling on the floor, holding the siderail of her bed. The Nursing Progress Note indicated Resident 1 complained of a pain rated 10 out of 10 to her left leg (later determined at the GACH to be the right leg/knee) and the same day (10/10/2024) was transferred to a General Acute Hospital (GACH) at 2:30 a.m. During a review of Resident 1's Order Summary report (Physician's Order), dated 10/10/2024, the Physician's Order indicated to transfer Resident to a GACH for further evaluation due to a fall. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of the GACH's Emergency Department (ED) documentation dated 10/10/2024 and timed at 2:45 a.m., the ED documentation indicated Resident 1 presented with a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) and deformity (a part of someone's body which is not the normal shape because of injury or illness, or because they were born that way) with loss of sensation (ability to feel) to the area below her right knee after a non-syncopal (not cause by fainting) fall out of bed in the skilled nursing facility (SNF). The ED documentation indicated Resident 1 complained of a pain level of 10 out of 10 to the lower area of her right knee and was administered Morphine (a medication used to treat pain) for pain. The ED documentation indicated on 10/10/2024 at 4:11 a.m., Resident 1 had an Xray (special pictures of the inside of the body) of the right hip, pelvis, right knee, right tibia, and fibula, and the right femur (the thigh bone). The ED documentation indicated Resident 1 sustained an acute (severe and sudden in onset) minimally displaced (the break in the bone does not go all the way through) fracture of the right knee, tibia, and fibula. The ED documentation indicated on 10/10/2024 at 4:16 a.m., Resident 1 underwent a CT scan (a diagnostic imaging [picture] procedure that uses a combination of Xrays and computer technology to produce images of the inside of the body) of her abdomen and pelvis with contrast (a solution given to a patient before a CT scan to help make certain parts of the body appear more clearly in the images). The ED documentation indicated Resident 1 sustained a new compression fracture (a type of broken bone that can cause the vertebrae to collapse, making them shorter) of the T11 and T12 thoracic bones, as compared to a previous CT scan done on 3/14/2024. During a review of GACH's Orthopedic (a branch of medicine that focuses on the care of the bones, muscles and joints) Surgery Consultation notes dated 10/10/2024 and timed at 9:25 a.m., the Orthopedic Surgery Consultation notes indicated Resident 1's fractures could be treated with weight bearing restrictions (limitations placed on a patient's ability to bear weight on a specific part of their body, typically due to an injury or surgery) and a knee immobilizer (a removable device that maintains the stability of the knee). During a telephone interview on 10/25/2024 at 4:05 a.m., Resident 1's Responsible Party (RP) 1 stated over the past few months every time she visited Resident 1, she noticed Resident 1's bed was always in a high position and there was never a floor mat on the floor next to the Resident 1's bed. RP 1 stated she kept reminding nurses about her concerns. RP 1 stated the staff were aware that Resident 1 was legally blind and could get disoriented at times. RP 1 stated Resident 1 had a fall in the past at the facility and needed frequent supervision and a lot of reminders not to get up unassisted. RP 1 stated Resident 1 told her that she (Resident 1) was calling for assistance the night she fell (10/9/2024) because her pillow fell on the floor, no one came to help her get her pillow, so she (Resident 1) tried to get up to get the pillow herself and she rolled out of the bed. RP 1 stated she felt the facility was negligent because the fall precautions (a low bed and floor mats) the facility was supposed to provide, were not implemented all the time. RP 1 stated after Resident 1 fell and broke her backbones and her right knee, her pain become more difficult to control, and there were days she could not participate with the physical therapy ([PT] a health profession that uses physical activities and treatments to help people improve their movement and physical function) provided in the facility. RP 1 stated she was concerned that Resident 1's condition would get worse. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/28/2024 at 6:14 a.m., Certified Nursing Assistant 2 (CNA 2) stated Resident 1 could be forgetful at times and needed supervision and frequent reminders to call for assistance. CNA 2 stated Resident 1 had a fall in the past and had floor mats in place on each side of her bed, but for the past couple of months (not sure how long) there had been no floor mats at Resident 1's bedside and she was not sure why. CNA 2 stated the floor mats could have helped lessen the impact when Resident 1 fell (10/10/2024) and might have helped prevent Resident 1's injuries. During an interview on 10/28/2024 at 6:39 a.m., CNA 4 stated Resident 1 had a floor mat in place on the right side of her bed only because Resident 1 had a tendency to lean on that side of the bed. CNA 4 stated she did not expect Resident 1 to fall off the left side of her bed. During a telephone interview on 10/28/2024 at 9:59 a.m., Licensed Vocational Nurse (LVN) 4 stated she found Resident 1 kneeling on the bare floor, on the left side of her bed while holding onto the bed's siderail. LVN 4 stated she had to lower Resident 1's bed when she assisted Resident 4 during the fall incident. LVN 4 stated Resident 1's injuries might have been prevented or minimized if there had been floor mats in place and her bed was in a low position, per her care plan. During an interview on 10/28/2024 at 12:43 p.m., the Assistant Director of Nursing Services stated the nursing staff were expected to implement fall precautions intervention as indicated in the resident's care plan and as ordered by the doctor. During a review of the facility's Policy and Procedure (P/P) titled NP04 Comprehensive Person-Centered Care Planning revised 8/24/2023, the P/P indicated the facility provides a person-centered, comprehensive, and interdisciplinary care that reflects the best practice standards for meeting the health, safety, psychosocial, behavioral, environmental needs of the residents in order to obtain or maintain their highest physical, mental, and psychosocial well-being. The P/P indicated the residents' care plan must be developed and implemented based on the residents' goals and objectives. 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 shall provide the residents a safe environment.