

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 11/01/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889</p> <p>Based on observation, interviews and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) no later than two hours for one of one sampled resident (Resident 1) when Resident 2 pulled Resident 1 ' s beanie (small close fitting hat) off her head and had her hair pulled.</p> <p>This failure had the potential to result in unidentified abuse in the facility and the failure to protect residents from abuse.</p> <p>Findings</p> <p>During a review of Resident 1 ' s Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis (nerve damage disrupting communication between the brain and body), heart failure (heart muscle is unable to pump enough blood to meet the body ' s needs for blood and oxygen), and muscle weakness.</p> <p>During a review of Resident 1 Minimum Data Set (MDS a federally mandated resident assessment tool), dated 5/23/2024 indicated Resident 1 was independent in making decisions for herself.</p> <p>During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder ((a mental illness that can affect thoughts, mood, and</p> <p>behavior), depression (mental health condition that involves a persistent low mood or loss of interest in activities) , restlessness and agitation, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs),chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated, Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment.</p> <p>During a review of Resident 2 ' s Change of Condition Evaluation dated 10/29/2024, indicated Resident 2 was transferred to general acute care hospital (GACH) on 10/29/2024 for continuously pulling the fire alarm and becoming physically and verbally aggressive with the 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/2024 at 5:50 a.m., with Resident 1, Resident 1 stated that 2 days ago (10/29/2024) while on the smoking patio around 6:30 p.m., Resident 2 pulled her beanie off her head and pulled her hair. Resident 1 stated she told the Administrator (ADM) the next day (10/30/2024).</p> <p>During a phone interview on 11/1/2024 at 11:30 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 2 did take the beanie off Resident 1 ' s head on 10/29/2024. CNA 1 stated that Resident 1 and Resident 2 were separated, and CNA 1 reported it to the Licensed Vocational Nurse (LVN).</p> <p>During an interview on 11/1/2024 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that CNA 1 did report to him that Resident 2 pulled Resident 1 ' s beanie off her head and that Resident 1 was mad. LVN 1 stated both residents were separated. LVN 1 stated he forgot to report it to the Administrator (ADM) because he had a lot of work to do that day (10/29/2024). LVN 1 stated, he was a mandated reporter and should have reported the incident. LVN 1 stated it was his obligation to report any allegation of abuse to ensure resident and staff safety and prevent further abuse.</p> <p>During a phone interview on 11/1/24 at 3:35 p.m., with the ADM, the ADM stated that any allegation of abuse should be reported within two hours to CDPH. The ADM stated the incident between Resident 1 and Resident 2 was not reported to him. The ADM stated all allegations of abuse should be reported and investigated to ensure resident ' s safety and that residents deserve to live in an abuse free environment.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Abuse Prevention and Management dated /12/2024, indicated, The Administrator or designated representative will notify law enforcement by telephone immediately, or as soon as practicably possible, but no longer than 2 hours of an initial report and send a written SOC 341 report to the Ombudsman, Law Enforcement, and California Department of Public Health (CDPH) within two hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889</p> <p>Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to submit a five-day investigative report for one of one sampled resident's (Resident 1).</p> <p>This deficient practice resulted in an incomplete investigation and incomplete conclusion of the alleged abuse in the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis (nerve damage disrupting communication between the brain and body), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and muscle weakness.</p> <p>During a review of Resident 1 Minimum Data Set (MDS a federally mandated resident assessment tool), dated 5/23/2024 indicated Resident 1 was independent in making decisions for herself.</p> <p>During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder ((a mental illness that can affect thoughts, mood, and behavior), depression (mental health condition that involves a persistent low mood or loss of interest in activities), restlessness and agitation, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment.</p> <p>During a review of Resident 2's Change of Condition Evaluation dated 10/29/2024, indicated Resident 2 was transferred to general acute care hospital (GACH) on 10/29/2024 for continuously pulling the fire alarm and becoming physically and verbally aggressive with the staff.</p> <p>During an interview on 10/31/2024 at 5:50 a.m., with Resident 1, Resident 1 stated that 2 days ago (10/29/2024) while on the smoking patio around 6:30 p.m., Resident 2 pulled her beanie off her head and pulled her hair. Resident 1 stated she told the Administrator (ADM) the next day (10/30/2024).</p> <p>During a phone interview on 11/1/2024 at 11:30 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 2 did take the beanie off Resident 1's head on 10/29/2024. CNA 1 stated that Resident 1 and Resident 2 were separated, and CNA 1 reported it to the Licensed Vocational Nurse (LVN).</p> <p>(continued on next page)</p>		

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