

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  12/03/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39028</p> <p>Based on observation, interview, and record review the facility failed to protect the residents ' right to be free from verbal and physical abuse by Certified Nursing Assistant (CNA 1) for one of three sampled residents (Resident 1). The facility failed to:</p> <p>a. Ensure CNA 1 did not yell at Resident 1 and threw the urinal and bottle of water towards Resident 1.</p> <p>b. Ensure CNA 1 waited for Resident 1 to finish using the bathroom and not enter the bathroom when Resident 1 pleaded for CNA 1 to wait before entering.</p> <p>These deficient practices resulted in Resident 1 feeling emotional , disrespected and a potential psychological distress (a state of emotional suffering that can include symptoms of anxiety ( a mental health condition that involves persistent and excessive feelings of fear or anxiety that can interfere with daily life), and depression [mental health condition that can impact a person's thoughts, feelings, behavior, and sense of well-being ]).</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 muscle weakness, anxiety, major depressive disorder ( a mood disorder that causes a persistent feeling of sadness and loss of interest, and schizophrenia ( a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 10/10/24, the MDS indicated Resident 1 had intact cognitive (ability to make decisions, understand, learn skills for daily decision making) ability. The MDS indicated Resident 1 required supervision with oral hygiene, toileting, shower, personal hygiene, bed mobility, transfer, locomotion on unit and off unit, dressing, eating, toilet, and personal hygiene.</p> <p>During a review of Resident 1's History and Physical (H&amp;P) dated 10/3/2024 indicated Resident 25 had the capacity to understand and make decisions.</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 0600</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 Care Plan titled Resident 1 is at risk for a psychosocial well-being problem related to episode of disagreement with Certified Nursing Assistant (CNA 1) dated 11/17/24, the Care plan interventions indicated to encourage Resident 1 to verbalize feelings and concerns, listen to resident concerns and follow up with appropriate intervention to the problem, monitor resident's whereabouts and assessed for any emotional distress.</p> <p>During a review of Resident 1 ' s Care Plan titled Resident for psychosocial disturbance /trauma related to disagreement with nurse dated 11/17/24, the Care Plan goal indicated Resident 1 will not have any negative effect emotionally because of the incident for 90 days. The Care Plan interventions included to encourage Resident 1 to verbalize feelings and concerns, listen to resident concerns and follow up with appropriate interventions to the problem.</p> <p>During a review of Nurses Progress Note dated 11/17/24 timed at 1:00 p.m., indicated on 11/17/2024 around 7:30 a.m., Resident 1 reported that he had a disagreement with a CNA 1, when CNA 1 wanted to empty the urinal while Resident 1 was still in the bathroom. The Nurses Progress note indicated CNA 1 responded with attitude (someone replied to a question or comment in a way that conveyed a negative or disrespectful feeling). Resident 1 stated CNA 1 threw a drinking cup towards him while he was inside the bathroom.</p> <p>During a review of Situation, Background, Assessment, Recommendation (SBAR-is a verbal or written communication tool that helps provide essential, concise information), dated 11/17/24, the SBAR indicated Resident 1, stated He had a disagreement with CNA 1 when CNA 1 wanted to empty the urinal while Resident 1 was in the bathroom. The SBAR indicated CNA 1 responded with attitude. The SBAR indicated CNA 1 threw a drinking cup towards him inside the bathroom and was very disrespectful. The SBAR indicated the incident affected Resident 1 emotionally.</p> <p>During a review of Interdisciplinary team (IDT- a collaborative meeting where various healthcare professionals work together to plan and coordinate resident care) note dated 11/18/24 indicated members of IDT met with Resident 1 to discuss the incident (yelling and throwing urinal and water bottle) that occurred on 11/17/24 regarding CNA 1 who had an altercation with the resident. Resident 1 stated The nurse threw a urinal at me and could not give me privacy while I was in the toilet.</p> <p>During a review of Resident 1's Physician Progress Note dated 11/19/24, the Physician Progress note indicated Resident 1 takes olanzapine ( medication used to treat the symptoms of schizophrenia) five milligram (mg unit of measurement) , one tablet for schizophrenia as manifested by anger, fluoxetine (medication used to treat depression) one tablet by mouth, trazodone (medication used to treat depression) 50 mg. The Physician Progress Note indicated Resident 1 has frequent recurrence of anxiety, extreme sensitivity to stressors, constant anxiety, and episodes of nightmares. The Physician Progress note indicated Resident 1 reported increased anxiety and worry.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 11/21/24 at 1:39 p.m., observed Resident 1 coming out from the bathroom, Resident 1 refused to talk about the incident on 11/17/2024 between him and CNA 1. Resident 1 stated he does not want to talk about it again because he complained to staff and called the police. Resident 1 stated everyone in the facility was aware of what happened on 11/17/2024. Resident 1 stated CNA 1 always like to come to the bathroom whenever he was using the bathroom. Resident 1 stated he does not like that he threw a cup of water on CNA 1. Resident 1 stated CNA 1 threw the urinal and bottle of water on him. Resident 1 stated CNA 1, was very disrespectful, invading his privacy while using the bathroom, even when he asked CNA 1 to wait so that he can finish using the bathroom. Resident 1 stated CNA 1 refused to wait.</p> <p>During a telephone interview on 11/21/24 at 1:50 p.m., with CNA 1, CNA 1 stated she was not feeling well when she came in to work on 11/17/2024 at 11 p.m. but asked by the charge nurse to stay until 6 a.m. CNA 1 stated, she started changing the residents and emptying urinals, and wanted to go empty the urinals in Resident 1 ' s bathroom while Resident 1 was in the bathroom. CNA 1 stated she knocked on the bathroom door and nobody responded so she went in. CNA 1 stated she told Resident 1 she was here to pick up the urinals, Resident 1 asked if she can wait until he finished using the bathroom. CNA 1 stated that she cannot wait as she only has 10 minutes. CNA 1 stated Resident 1 came out of the bathroom and threw water towards her. CNA 1 stated Resident 1 asked her to clean the spilled water in his room and she responded, I am not housekeeping. CNA 1 stated Resident 1 threw urinals in the hallway.</p> <p>During an interview on 11/21/2024 at 2:58 p.m., with Social Service (SS) staff, SS stated CNA 1 was wrong in throwing water and urinal back towards Resident 1. SS staff stated CNA 1 should not have thrown back water on Resident 1. SS staff stated CNA 1 should have reported to the incident to the charge nurse.</p> <p>During an interview on 12/3/2024 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was at the nursing station when Resident 1 came to the nursing station looking for the supervisor. LVN 1 stated, Resident 1 told him that CNA 1 threw the urinal and water on him while he was in the bathroom. LVN 1 stated CNA 1 enter the bathroom without knocking on the door to collect the urinals. LVN 1 stated Resident 1 asked CNA 1 to wait until he was done using the bathroom, but CNA 1 responded she does not have time to wait until Resident 1 finished using the bathroom. LVN 1 stated, CNA 1 started collecting the urinals in the bathroom even after Resident 1 told CNA 1 he still needs the urinals. LVN 1 stated, Resident 1 got upset and threw water and the urinals on CNA 1. LVN 1 stated CNA 1 threw urinals and water bottle back on Resident 1. LVN 1 stated when she asked CNA 1 if Resident 1 ' s allegations was true, CNA 1 responded that Resident 1 was rude to her, and she did not have the time to wait for Resident 1 to finish using the bathroom. LVN 1 stated CNA 1 had previous altercation with Resident 1 and does not like to be assigned with Resident 1.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled Abuse Prevention, and Reporting dated 6/12/2024, the P&amp;P indicated The purpose of abuse prevention as to address the health, safety, welfare, dignity, and respect of residents by prevention abuse, neglect, misappropriation of resident property, exploitation, and mistreatment including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat medical symptoms. The P&amp;P indicate Verbal Abuse as any use of oral, written, gestured communication, or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, regardless of age, ability to comprehend, or disability.</p>		