

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  02/27/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44443</b></p> <p>Based on interview, and record review, the facility failed to ensure their front door was alarmed to prevent a resident who was under conservatorship (a legal status in which a judge appoints a person [conservator] to manage the financial and personal affairs of a minor incapacitated person), who wandered (random or repetitive locomotion maybe goal directed, or non-goal directed) around the hallways in the facility, and was assessed incorrectly during her elopement evaluation, did not elope (act of leaving a facility unsupervised and without prior authorization) from the facility for one of three sampled residents (Resident 1).</p> <p>This deficient practice resulted in a care plan not being created for Resident 1 based on an incorrect elopement evaluation (12/24/2024) and no interventions in place to address Resident 1's elopement risk. Resident 1 eloped from the facility on 2/24/2025 between 6 a.m., when she was last seen during a blood pressure check, and 7 a.m., when she was not found in her room during morning rounds. Resident 1 was found approximately four miles from the facility on the same day (2/24/2025) at 10:27 a.m. (approximately four hours and 30 minutes after she was last seen in the facility). This deficient practice placed Resident 1 at risk for confusion, injury and continued inability to locate her.</p> <p>Findings:</p> <p>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 diagnosis including schizophrenia (a mental illness that is characterized by disturbances in thought), brief psychotic disorder (a mental health condition characterized by a sudden onset of psychotic symptoms that last for at least one day but less than one month), generalized anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry about a variety of everyday events), dementia (a progressive state of decline in mental abilities), and aphasia (a disorder that makes it difficult to speak).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/19/2024, the MDS indicated, Resident 1's cognition (thinking) was moderately impaired. The MDS indicated Resident 1 required supervision or touch assistance for walking.</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 0689</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 Elopement Evaluation dated 8/29/2024, the Elopement Evaluation indicated Resident 1 has a history of elopement or attempted leaving the facility without informing staff and Resident 1 did wander. Continued review of the Elopement Evaluation indicated there was no goals, interventions or clinical suggestions checked.</p> <p>During a review of Resident 1's Elopement Evaluation dated 12/24/2024, the Elopement Evaluation indicated, Resident 1 did not have a history of elopement or attempted leaving the facility without informing staff and Resident 1 did not wander.</p> <p>During a review of Resident 1's SBAR ([Situation, Background, Assessment, Recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/24/2025, the SBAR indicated at 7:34 a.m., Certified Nursing Assistant (CNA) 3 reported to Licensed Vocational Nurse (LVN) 2 that Resident 1 was not in her room. The SBAR indicated LVN 2 performed a sweep of the facility and Resident 1 was not found.</p> <p>During a review a local area Police Department's Missing Person's Report dated 2/24/2025, the Police Department's Missing Person's Report indicated Resident 1 was located and identified at 10:27 a.m., approximately four miles from the facility, wearing a yellow sweater, brown skirt, and gray socks. The Police Department's Missing Person's Report indicated Resident 1 was evaluated and transported to a General Acute Care Hospital (GACH) where she was placed on a medical hold (a temporary involuntary detention of a patient in a hospital allowing for medical examination and treatment when the patient lacks the capacity to make informed decisions).</p> <p>During a review of a Paramedic Run Sheet (a document that records information about a patient's encounter with ambulance services) dated 2/24/2025, the Paramedic Run Sheet indicated Resident 1 was found by a local area police department walking on the sidewalk confused, mumbling incoherently (unclear, confusing speech), and wearing approximately 10 layers of clothing.</p> <p>During a concurrent interview and record review on 2/25/2025, at 7:37 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 1's Elopement Evaluation dated 12/24/2024 was reviewed. The Elopement Evaluation indicated Resident 1 did not wander. RNS 1 stated Resident 1 was not a wanderer but stated she (Resident 1) walked the hallways most of the time, but she did not wander into other resident's rooms, nor had she attempted to leave the facility.</p> <p>During an interview on 2/25/2025, at 9 a.m., CNA 3, stated, on 2/24/2025 when he was making his morning rounds at 7 a.m., Resident 1 was not in her bed. CNA 3 stated he asked Resident 1's roommates (Resident 2 and Resident 3) who were alert, if they knew where Resident 1 was, and both said they had not seen Resident 1. CNA 3 stated, Resident 1 constantly walks around the hallways all the time and would always stop and stare at the front door but would never walk towards the front door or exit the facility, that was why he (CNA 3) did not notify anyone of her behavior.</p> <p>During an interview on 2/25/2025, at 9:40 a.m., the Administrator (ADM) stated, none of the cameras inside or outside of the facility had been working since 11/18/2024, and when Resident 1 eloped (2/24/2025), the alarm on the front door was not turned, and the alarm should have been turned on. The ADM stated the licensed nurses were responsible for turning on and activating the alarm at the front entrance and it was important that the front door's alarm is on to alert staff if a resident attempts to exit the facility. The ADM stated Resident 1 probably eloped from the facility through the front door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/2025, at 12:55 p.m., LVN 1 stated, the last time she saw Resident 1 was on 2/24/2025 after 6 a.m., when she took Resident 1's 1 blood pressure. LVN 1 stated the alarm at the front door was not turned on the during the night/morning that Resident 1 eloped because there were CNAs and licensed nurses sitting at the front nurses station, which is close to the front entrance of the facility. LVN 1 could not say if the nurses were at the front nurse's station the entire time.</p> <p>During a concurrent interview and record review on 2/26/2025, at 1:47 p.m., with the Maintenance Supervisor (MS), the Wander Guard/Red Alarm Monitoring Logs were reviewed. The Monitoring Log indicated the alarms for the three doors in the facility were checked daily Monday through Friday but not on the weekends or after hours. The MS stated he checked the alarms during the week, Monday through Friday, but he gets off work at 530 p.m., so he is not there to check if the alarms are on after that time.</p> <p>During an interview on 2/26/2025, at 4:20 p.m., the Receptionist (RCP) stated he works Monday through Friday, and his shift ends at 9 p.m., when he leaves the facility, he locks the front door from the outside, but he did not turn on the alarm because he was never instructed to do so.</p> <p>During an interview on 2/27/2025, at 5:14 p.m., after reviewing Resident 1's Elopement Evaluation dated 8/29/2024 the Director of Nursing (DON) stated, Resident 1 was an elopement risk since she had a history of elopement or attempting to leave the facility without informing staff. The DON stated, a history of means Resident 1 attempted to leave a facility in the past and a care plan should have been developed with goals and interventions per the prompting of Question 12 on Resident 1's Elopement Evaluation, along with completing the Clinical Suggestions (interventions). The DON stated staff should have been notified of Resident 1's wandering/elopement risk so she (Resident 1) could have been monitored closely to prevent her from eloping from the facility.</p> <p>During a review of the facility's Policy and Procedure (P/P) titled, Wandering and elopement revised 1/31/2023, the P/P indicated the facility will identify residents at risk for elopement upon admission and when there is a change in condition to minimize the risk of elopement. The purpose is to enhance the safety of residents of the facility.</p>		