

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  07/11/2025
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)
F 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to readmit one of three sampled residents (Resident 3) after Resident 3 was transferred to a General Acute Care Hospital (GACH) to evaluate a distended (swollen or enlarged) abdomen with pain on 6/7/2025. This failure resulted in Resident 3 experiencing a prolonged stay at the GACH and frustration from not being able to return the facility which he considered to be his home. Findings: During a review of Resident 3's admission record, the admission record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs) and hydronephrosis (swollen kidneys due to blockage in the urinary tract). During a review of Resident 3's History and Physical (H&amp;P), dated 1/31/2024, the H&amp;P indicated Resident 3 was able to make decisions for activities of daily living. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 3's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 3 required set-up assistance for eating and oral hygiene, and required supervision for toileting and dressing. During a review of Resident 3's Change of Condition (COC) Evaluation dated 6/7/2025, the COC Evaluation indicated Resident 3 had a bloated and distended abdomen that was hard when touched accompanied by pain on 6/7/2025. The COC Evaluation indicated the medical doctor ordered for Resident 3 to be transferred to the GACH. During an interview on 7/11/2025 at 11:22 a.m., with Resident 3, Resident 3 stated the GACH Case Manager told him the facility does not have an available bed for him to return to. Resident 3 stated he was frustrated and has been waiting to be discharged. Resident 3 stated he wants to return to the facility because it is his home, and it is near his family. During an interview on 7/11/2025 at 2:32 p.m., with the Admissions Coordinator (AC), the AC stated she received a call on 6/26/2025 from the GACH Case Manager (CM) 2 inquiring about Resident 3 returning to the facility. The AC stated she told the GACH CM 2 there were no available male beds at this time. The AC stated this was the only communication she had with the GACH. During a review of Resident 3's GACH Order Summary, the Order Summary indicated Discharge to Skilled Nursing Facility (SNF) was active on 6/27/2025 at 2:17 p.m. During an interview on 7/11/2025 at 11:41 a.m., with the GACH Case Manager (CM) 1, CM1 stated Resident 3 has had an active discharge order since 6/27/2025 and the discharge order was still active as of 7/11/2025. GACH CM 1 stated Resident 3 is waiting for placement to a nursing facility. During a review of Resident 3's GACH Case Management Progress Notes dated 6/28/2025 11:17 a.m., the Progress Notes indicated the GACH contacted the facility and was told the Director of Nursing (DON) is not able to accommodate Resident 3 due to new admissions. During a concurrent interview and record review on 7/11/2025 at 2:48 p.m., with the Director of Nursing (DON), the facility Census and Bed Assignments for 6/10/2025 to 7/11/2025 were reviewed. The Facility Census and Bed Assignment indicated one available male bed from 6/27/2025 - 6/29/2025, two available male beds from 6/30/2025 - 7/1/2025, and one available male bed from 7/2/2025 - 7/6/2025. The DON stated there was at least one available male bed from 6/27/2025 to 7/6/2025, 11 consecutive days. The DON stated the facility is the resident's home, and we try to accommodate them back to the facility including when the seven-day bed-hold expires. The DON stated, if the bed was available, the resident should have returned to the facility. During a review of the facility's policy and procedure (P&amp;P), titled Bed Hold, revised July 2017, The P&amp;P indicated, In the event that the resident is in the hospital for more than seven (7) days, meets the standards for skilled nursing care, and is Medi-Cal/Medicaid eligible, the Facility will readmit the resident to his/her previous room or the first available bed in a semi-private room.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to review and revise a care plan for one of three sampled residents when Resident 2 was readmitted to the General Acute Care Hospital (GACH) on 6/23/2025 after being transferred to the GACH for aggressive behavior on 6/10/2025. This failure resulted in Resident 2 throwing a book at Resident 1 on 6/27/2025. Findings: During a review of Resident 2's admission record, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (damage or disease that affects brain function), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 2's History and Physical (H&amp;P), dated 1/31/2024, the H&amp;P indicated Resident 2 had fluctuating capacity and was able to make decisions for activities of daily living. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/27/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 2 required supervision for eating and oral hygiene, and required moderate assistance for toileting, bathing, and dressing. During a concurrent interview and record review on 7/11/2025 at 12:11 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 2's medical record was reviewed. The MDSC stated Resident 2 was transferred to a General Acute Care Hospital (GACH) on 6/10/2025 for a behavior of yelling and striking out at staff. The MDSC stated on 6/10/2025, Resident 2's care plans were updated to include an intervention of 1:1 supervision as ordered for safety. The MDSC stated Resident 2 was readmitted to the facility on [DATE] but did not require 1:1 supervision because Resident 2 was not aggressive. The MDSC stated Resident 2's behavior care plans were not revised upon readmission on [DATE], but should have been reviewed and revised to provide the appropriate care to the resident. The MDSC stated Resident 2 threw a book at Resident 1 on 6/27/2025. The Psychiatric Follow up Note date 6/27/2025 indicated Resident was observed to be anxious, irritable, emotionally labile, exhibited signs of poor impulse control and unpredictable behavior, with angry outbursts. The Psychiatric Follow up Note indicated a recommendation to transfer Resident 2 to an inpatient psychiatry facility on 7/27/2025 for stabilization. The MDSC stated more frequent resident supervision, such as 1:1 supervision could prevent resident-to-resident altercations. During an interview on 7/11/2025 at 4:01 p.m., with the Director of Nursing (DON), the DON stated care plans need to be updated when residents are readmitted. The DON stated if we don't review and update care plans, there may be a gap or delay of care to residents. During a review of the facility's policy and procedure (P&amp;P), titled Comprehensive Person-Centered Care Planning, revised 8/24/2023, The P&amp;P indicated comprehensive car.</p>		