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	11/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of abuse to the state agency (Department of Public health) for two of three sampled residents (Resident 1 and Resident 2) who were engaged in verbally aggressive behavior. This deficient practice resulted in a delay in an onsite inspection by the State Agency and had the potential to place other residents at risk for unaddressed abuse and unsafe interactions. Findings:During a review of Resident 1's admission Record (Face sheet) dated 9/22/2025, the admission Record indicated the facility admitted Resident 1 on 1/29/2025 and was readmitted on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swing that range from the lows of depression to elevated periods of emotional highs), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that is characterized by disturbance in thought), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/16/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. Resident 1 required minimal assistance from staff with eating and dressing. Resident 1 was nicotine dependent and smoked cigarettes daily and used a manual wheelchair for mobility (ability to wheel at least 50 feet and make turns without assistance from staff). During a review of Resident 1's History and Physical (H&P) dated 6/12/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Change In Condition (COC) evaluation note dated 8/10/2025, the COC indicated Resident 1 was noted outside the patio when Resident 2 spoke to her in a loud tone. Resident 1 stood up in response, but no physical contact occurred. The note indicated Resident 1's behavior warranted a behavioral assessment due to verbal aggression, noted as cursing and screaming. During a review of Resident 2's admission Record (Face sheet), the admission Record indicated the facility admitted Resident 2 on 7/2/2025 and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder and restless and agitation.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact. Resident 2 required minimal assistance from staff for eating, dressing and bathing. Resident 2 was able to walk with minimal staff supervision. Resident 2 was nicotine dependent and smoked cigarettes daily.During a review of Resident 2's H&P dated 8/23/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Change In Condition (COC) evaluation note dated 8/10/2025, the COC indicated Resident 2 was observed smoking outside on the patio and began making inappropriate comments towards other residents.During a review of Resident 2's Psychiatric Note dated 8/10/2025, the Psychiatric Note indicated Resident 2 had exhibited increased aggression towards another resident. During an interview on 9/22/2025 at 11:30 a.m., with Resident 1, Resident 1 stated, Resident 2 called her a fat white bitch after refusing to give him cigarettes. During an interview on 9/22/2025 at 12:45 p.m., with the Social Service assistant (SSA), the SSA stated, she heard about an incident of verbally aggressive behavior between Resident 1 and Resident 2 but knew nothing else about it and stated all abuse verbal and physical must be reported to the administrator (ADM) or supervisor immediately. During an interview on 9/22/2025 at 1:35 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1 and Resident 2 were observed being verbally aggressive towards each other while out on the smoking patio. LVN 1 stated, Resident 1 and Resident 2 were getting very close to each other angry and aggressive over cigarettes. LVN 1 stated he separated the residents. LVN 1 stated, all abuse allegations are reportable verbal and physical. LVN 1 stated the verbally aggressive behavior between Resident 1 and Resident 2 was reported to the supervisor. During an interview on 9/22/2025 at 2:45 p.m., with Registered Nurse (RN) 1, RN 1 stated she was the supervisor on the day of the incident and was aware Resident 1 and Resident 2 were shouting back and forth over cigarettes. During an interview on 9/22/2025 at 3:30 p.m., with the Director of Nurses (DON), the DON stated she did not report the incidents of verbal aggression between Resident 1 and Resident 2. The DON stated allegations of abuse, verbal and physical are investigated and reported. During an interview on 9/23/2025 at 3:00 p.m., with Registered Nurse (RN) 2, RN 2 stated she was made aware of the verbal aggressive behavior that occurred between Resident 1 and Resident 2 but did not report the incident.During an interview on 9/23/2025 at 3:00 p.m., with the Administrator (ADM), the ADM stated he was notified of the verbal aggressive behavior incident involving Resident 1 and Resident 2. The ADM stated this incident was not

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an incident of verbal abuse for two of three sampled residents (Resident 1 and Resident 2).This deficient practice resulted had the potential to place residents at risk for ongoing abuse. Findings:During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 1 on 1/29/2025 and was readmitted on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swing that range from the lows of depression to elevated periods of emotional highs), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that is characterized by disturbance in thought), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/16/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. Resident 1 required minimal assistance from staff with eating and dressing. Resident 1 was nicotine dependent and smoked cigarettes daily and used a manual wheelchair for mobility (ability to wheel at least 50 feet and make turns without assistance from staff).During a review of Resident 1's History and Physical (H&P) dated 6/12/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1‘s Change In Condition (COC) evaluation note dated 8/10/2025, the COC evaluation noted indicated Resident 1 was noted in the smoking patio when Resident 2 spoke to her in a loud tone. Resident 1 stood up in response, but no physical contact occurred. The note indicated Resident 1's behavior warranted a behavioral assessment due to verbal aggression, noted as cursing and screaming.During a review of Resident 2's admission Record (Face Sheet), the admission Record, indicated the facility admitted Resident 2 on 7/2/2025 and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder and restless and agitation.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact. Resident 2 required minimal assistance from staff for eating, dressing and bathing. Resident 2 was able to walk with minimal staff supervision. Resident 2 was nicotine dependent and smoked cigarettes daily.During a review of Resident 2's H&P dated 8/23/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Change In Condition (COC) evaluation note dated 8/10/2025, the COC indicated Resident 2 was observed smoking outside on the patio and began making inappropriate comments towards other residents.During a review of Resident 2's Psychiatric Note dated 8/10/2025, the Psychiatric Note indicated Resident 2 exhibited increased aggression towards another resident. During an interview on 9/22/2025 at 11:30 a.m., with Resident 1, Resident 1 stated, Resident 2 called her a fat white bitch after refusing to give him cigarettes.During an interview on 9/22/2025 at 1:35 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1 and Resident 2 were observed being verbally aggressive towards each other while out on the smoking patio. LVN 1 stated, Resident 1 and Resident 2 were getting very close to each other angry and aggressive over cigarettes. LVN 1 stated he separated the residents. LVN 1 stated the verbally aggressive behavior between Resident 1 and Resident 2 was reported to the supervisor and was not considered verbal abuse. LVN 1 stated that verbal abuse should be investigated and reported to licensing department.During an interview on 9/23/2025 at 3:00 p.m., with the Administrator (ADM), the ADM stated he was notified of the verbal aggressive behavior incident involving Resident 1 and Resident 2. The ADM stated this incident was not investigated as a verbal or physical abuse because he was only aware of verbal aggressive behavior. The ADM stated any delay in investigating has the potential to put residents' safety at risk. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Management revised 5/30/2024 the P&P indicated, Abuse is defined as the willful, deliberate infliction of injury. Abuse includes verbal and physical. allegations of abuse or reasonable suspicion of a crime are to be reported to the administrator or designated representative immediately.When the Administrator or designated representative receives a report of an allegation of resident abuse.the Administrator or designated representative, will initiate and investigation immediately.