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	11/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary staff (Cook 1, [NAME] 2, Dietary Aid 1 [DA1] and, Dietary Aid 2 [DA 2]) wore appropriate hair and beard nets in the kitchen while preparing or handling food for 73 out of 104 residents in the facility who received meals prepared in the kitchen. This deficient practice had the potential to increase the risk of foodborne illness and affect 73 of 104 residents who received meals prepared in the facility kitchen.Findings: During a concurrent observation and interview on 10/29/2025 at 8:30 a.m. with the Dietary Supervisor (DS) in the kitchen, [NAME] 1 was observed with a hair net that did not cover the back of her head and both sides of her hair, and [NAME] 2, who had a beard, did not have on a beard net in the food preparation and stove area. The DS stated [NAME] 1's hair net did not cover the back of her head and both sides around her ears and [NAME] 2 did not wear a bead net. The DS stated the requirement was to cover the hair in the kitchen and it was essential to prevent hair falls into food and causing foodborne illness, and they prepared food portions for 83 residents that morning. During a concurrent observation and interview on 10/29/2025 at 9:25 a.m. with the DS in the kitchen, there were no beard nets available in the kitchen entrance for use. The DS stated, DA 1 and DA 2 who had beards were not wearing beard nets. The DS stated dietary staff with beards must always wear the beard nets in the kitchen. The DS stated the beard nets were not available for use for three days and became available on 10/29/2025.During an interview on 10/29/2025 at 10:00 a.m. with the Director of Nursing (DON), the DON stated dietary staff are required to wear hair nets and beard nets in the kitchen as an infection control practice to prevent any hair to shed and causing food-borne illness.During a review of the facility's Daily Census Report, dated 10/28/2025, The Daily Census Report indicated there were total 104 residents in the facility for the day.During a review of the facility's policy and procedure (P&P), titled Dietary Department-Infection Control, revised 2/29/2024, the P&P indicated personal cleanliness is required in sanitary food preparation and to cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas.

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

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Cove Post Acute	1730 Grand Ave Long Beach, CA 90804

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow its Infection Control policy and procedure (P&P) titled Enhanced Barrier Precautions ([EBP] infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) when Licensed Vocational Nurse 1 (LVN 1) performed a dressing change, disconnected a feeding tube (a medical device used to deliver nutrients, fluids, and medications directly into the gastrointestinal tract) without wearing a gown or performing hand hygiene for one of one resident, (Resident 6), who was on EBP precautions.This deficient practice had the potential to place all residents at risk of infection and increase the risk of spreading microorganisms (bacteria, viruses or fungi) to residents and staff.Findings:During a review of Resident 6's admission Record, the admission Record indicated the facility readmitted Resident 6 on 7/30/2025 with diagnoses including dysphagia (difficulty swallowing food or liquids), gastrostomy ([G-tube] a surgically created opening into their stomach), and a tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] through the front of the neck).During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), dated 8/6/2025, indicated Resident 6's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills were severely impaired. The MDS indicated Resident 6 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, and personal hygiene. During a review of Resident 6's Order Summary Report, as of 10/29/30, indicated to start EBP on 7/30/2025, due to tracheostomy and G-tube status, every shift. During a concurrent observation and interview on 10/29/2025 at 10:10 a.m. with Licensed Vocational Nurse 1 (LVN 1) at Resident 6's room with a sign that indicated EBP requirements. LVN 1 was observed wearing gloves and placing an abdominal pad to the resident's tracheostomy site and disconnecting G-tube feeding from the resident's G-tube connector. LVN 1 did not wear a gown or perform hand hygiene prior to the tasks. LVN 1 stated she did not perform hand hygiene and wore a gown prior to her care. LVN 1 stated it was essential to wear a gown during care of Resident 6 and practice hand hygiene for infection control practices. During a concurrent interview and record review on 10/29/2025 at 2:30 p.m. with the Infection Prevention Nurse (IPN), Resident 6's Order Summary Report, dated 10/29/2025, was reviewed. The IPN stated Resident 6 was on EBP precautions. The IPN stated EBP precautions include wearing a gown and performing hand hygiene prior to high-contact tasks like changing dressings, and disconnecting tube feeding. During an interview on 10/29/2025 at 4:05 p.m. with the Director of Nursing (DON), the DON stated staff are required to follow EBP precautions for direct or high-contact tasks with a resident who had an EBP order as infection control. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 10/15/2025, the P&P indicated for residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities including dressing, device care or use: feeding tube, tracheostomy. The P&P indicated to facilitate compliance with EBP, staff are required to make personal protective equipment (PPE), including gowns and gloves are to be donned before each high contact task. The P&P indicated the facility incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices, such as hand hygiene and PPE use, to determine the need for additional training and education.