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	06/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to answer the call lights (device that allows residents to request assistance from nursing staff) for two out of three sampled residents (Resident 5 and 6) in a timely manner.These failures had the potential to result in delays of care and services, and negatively impact resident outcomes. Findings:During a review of Resident 5's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including lack of coordination and gastrointestinal hemorrhage (blood loss from the digestive tract).During a review of Resident 5's Minimum data Set ([MDS] a resident assessment tool), dated 6/5/2026, the MDS indicated Resident 5 had difficulty communicating some words or finishing thoughts but was able to if prompted or given time to express wants. The MDS also indicated Resident 5 misses some part/intent of message but comprehends most conversation. The MDS indicated Resident 5 needed substantial assistance (helper does more than half the effort) with personal hygiene and was dependent (helper does all the effort to complete the task) on staff with showering and toileting hygiene.During a review of Resident 6's Face Sheet, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (infection of the bone) of right foot and ankle, diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), and cellulitis (a skin infection that causes swelling and redness) of right lower limb.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 60 needed supervision with Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily).During an observation on 6/18/2026 at 10:38 a.m., in the Nursing Station, the call light panel was alarming, and the panel indicated three call lights were on and Registered Nurse Supervisor (RNS) 1 was sitting in the nursing station charting and not acknowledging the call lights. During a concurrent observation and interview on 6/18/2026 at 10:38 a.m., in the Nursing Station, the call light panel indicated Resident 5's call light was alarming for 28 minutes and two other call lights were on. RNS 1 stated according to the call light panel the call light was on for Resident 5 for 28 minutes and it should have been answered. During an interview on 6/18/2026 at 12:06 p.m., with Resident 6, in Resident 6's room, Resident 6 stated sometimes the nurses do not answer the call lights for a long time. Resident 6 stated sometimes the staff will see the call light on and continue they passed the room without acknowledging the activated call light, or checking on the resident using the call light During a concurrent interview and record review on 6/18/2026 at 12:16 p.m. with the Activities Director (AD), the facility's Resident Council Meeting Minutes, 5/26/2026, was reviewed, The AD stated the minutes indicated Resident 6 complained staff would help after waiting for an hour. The AD stated slow call light response of the staff was also an issue last meeting in 4/28/2026.During an interview on 6/18/2026 at 12:36 p.m., with Resident 5 in Resident 5's room, Resident 5 stated sometimes the nurses do not answer the call lights in a timely manner. During an interview on 6/23/2026 at 10:18 a.m. with the MDS Nurse (MDSN), the MDSN stated call lights need to be answered immediately so staff can attend to the residents' needs. The DON stated even if staff were in the room the other staff need to answer the (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light in case the staff needed help with the residents. During a review of the facility's policy and procedure (P&P) titled, P-NP29 Communication- Call System, revised 11/20218/24/2024, the P&P indicated the facility staff will answer call alerts promptly and in a courteous manner.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews the facility failed to ensure the Physical Therapy Assistant (PTA - staff who implement guided therapy), Occupational Therapist Registered (OTR - licensed professional who helps develop life skills through therapy), and the Certified Occupational Therapy Assistant (COTA - professional who help implement therapy) were wearing isolation gowns (personal protective equipment [PPE] - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing Physical Therapy services (healthcare treatments designed to help you move, reduce pain, recover from injuries, and manage chronic conditions) for one of one sample resident (Resident 2).The failure had the potential to result in the spread of dangerous germs that can cause severe infection. Findings:During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including retention of urine (the inability to completely or partially empty your bladder) and neuromuscular dysfunction of bladder (condition where nerve damage disrupts the signals between the brain and bladder preventing the bladder from properly storing or emptying urine). During a review of Resident 2's Minimum data Set ([MDS] a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 2 had intact cognition. The MDS indicated Resident 2 was dependent (helper does all the effort to complete the task) on staff with toileting hygiene. The MDS indicated Resident 2 had an indwelling catheter (flexible tube inserted into the bladder to drain urine).During a review of Resident 2's Order Summary Report, 6/4/2026, the order indicated enhanced barrier precautions ([EBP] infection control strategy used in nursing homes and skilled nursing facilities to prevent the spread of infections) for indwelling catheter status. During an observation on 6/18/2026 at 11:15 a.m., in the Rehabilitation Room, the OTR, PTA, and COTA, assisted Resident 2 stand up and ambulate with a two-wheel walker (mobility aid with wheels on the front tegs and rubber tips on the back legs) without wearing isolation gowns. The OTR, PTA, and COTA were all in prolonged contact with Resident 2.During an interview on 6/18/2026 at 2:20 p.m., in the Rehabilitation Room, with the OTR, the OTR stated they were not wearing isolation gowns and the OTR stated he was unsure if they had to wear one. During an interview on 6/23/2026 at 10:18 a.m., with the MDS Nurse (MDSN), the MDSN stated enhanced barrier precautions will prevent the spread of infection. The MDSN stated the Rehabilitation staff should have put on isolation gowns. During a review of the facility's policy and procedure (P&P) titled, IPC303 Enhanced Barrier Precautions, revised 10/15/2024, the P&P indicated for residents for whom EBP are indicated, EBP is employed when performing high-contact resident care activities for those at risk of transmission. The P&P indicated that according to the Centers of Disease Control, Therapists should use gowns and gloves when working with residents on EBP in the therapy gym if they anticipate prolonged, close body contact where transmission of multi -drug resistant organisms (germs that have developed resistance to medications) to the therapist's clothes is possible.