

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/08/2026
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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure: 1. A ventilator assisted individual ([NAME]) a person who relies on a medical device to completely or partially assist with their breathing) received appropriate airway management by ensuring the ventilator (a medical machine that helps or fully takes over the breathing process for a patient) was turned on after one of five sampled residents (Resident 1) was transported to her room following a shower. 2. A Respiratory Therapist ([RT]) a specialized health professional who diagnoses, treats, and manages patients with breathing and cardiopulmonary disorders) was available to monitor and manage Resident 1's airway. As a result, Resident 1 was connected to a portable ventilator (Vent 2) on [DATE] at 8:53 a.m., and Vent 1 was powered down (turned off) at 8:55 a.m. While powered down, Vent 1 was not able to alert staff, via alarms, that Resident 1 was not being ventilated. From 10:37 a.m., through 11:08 a.m., both RTs (RT 1 and RT 2) were on meal breaks and not monitoring Resident 1. At 11:08 a.m., Resident 1 was found with an odd skin tone (orange), unresponsive (a patient who fails to react or respond to external stimuli, such as voice, touch, or pain), without pulses, or an oxygen saturation level ([O2 sat] a measurement of how much oxygen the blood is carrying as a percentage normal range from 92% to 100%), and was subsequently pronounced deceased at 11:45 a.m., by paramedics. These deficient practices resulted in Resident 1's death and placed seven other [NAME] at risk for inadequate airway support that could result in serious medical complications, including death. On [DATE] at 5:39 p.m., an Immediate Jeopardy ([IJ]) a situation in which the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), the Director of Nursing (DON), the Regional Quality Management Consultant (RQMC), [NAME] President of Operations (VPO) 1, and VPO 2 due to the facility's failure to ensure Resident 1's airway was managed appropriately. An IJ Removal Plan ([IJRP]) a plan to immediately correct the deficient practices) was immediately requested. On [DATE] the facility submitted an acceptable IJRP. After onsite verification of the IJRP's implementation through observation, interview, and record review, the IJ was removed on [DATE] at 3:09 p.m., in the presence of the ADM, the DON, the RQMC, and a Registered Nurse Consultant (RNC). Non-compliance of F695 remained at the scope and severity of G actual harm that is not Immediate Jeopardy. The IJRP included the following: Effective 7/7/ 2026, the facility implemented a standardized Shower/Disconnection Verification Log to ensure safe ventilator disconnect/reconnect practices for all ventilator-dependent residents requiring transport, showering, or any other clinically necessary ventilator transition. Upon completion of the shower or transport and immediately following reconnection to the resident's prescribed ventilator, the RT will complete the Shower/Disconnection Verification Log. As part of this process, the RT will perform and documents a standardized verification to confirm: a. The resident is connected to the prescribed (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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately initiate Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) to one of five sampled residents (Resident 1), when Respiratory Therapist (RT) 1, who was CPR certified (successfully completed a training course and received a credential that qualifies a person to perform CPR), found Resident 1 unresponsive (a person is unconscious and fails to react to any external stimulation), without pulses and no oxygen saturation level ([O2 sat] a measurement of how much oxygen the blood is carrying as a percentage normal range from 92% to 100%) on [DATE] at 11:08 a.m. As a result, CPR was delayed when RT 1 confirmed Resident 1 was unresponsive by checking Resident 1's pulses and O2 sat level before leaving Resident 1 to obtain assistance, check Resident 1's code status (a patient's documented medical preferences regarding life-saving interventions), and retrieve the crash cart (a wheeled cart holding emergency medical supplies) before returning to Resident 1's room. RT 2 and Licensed Vocational Nurse (LVN) 2 returned to Resident 1's room with RT1 and reassessed Resident 1's pulses again multiple times before initiating CPR. In addition, 911 was not called until Registered Nurse (RN) 1 was made aware of the code blue at 11:11 a.m., entered Resident 1's room then left to contact 911 at 11:14 a.m. (five minutes after Resident 1 was found unresponsive). Resident 1 was pronounced deceased on [DATE] at 11:45 a.m., at the facility, by paramedics. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 had diagnoses including anoxic brain damage (an injury to the brain tissue caused by a complete lack of oxygen reaching the brain), tracheostomy (a surgically created opening in front of the neck leading directly into the windpipe to help a person breathe), and was dependent on a respiratory ventilator. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had severe cognitive (a person's brain function, memory, and orientation) impairment. The MDS indicated Resident 1 was dependent on staff for activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician Orders for Life-Sustaining Treatment ([POLST] a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated [DATE], the POLST indicated if Resident 1 was in cardiopulmonary arrest (the sudden, unexpected cessation of breathing and blood circulation when the heart stops pumping blood properly or abruptly stops beating) CPR was required. During a review of Resident 1's RT Progress Note, dated [DATE] and timed at 1:28 p.m., the RT Progress Note indicated at 11:09 a.m., RT 1 entered Resident 1's room to administer a breathing treatment when Resident 1 was noted with a change in skin color. RT 1 checked Resident 1's O2 sat, there was no O2 sat level, suctioned Resident 1's airway (via her tracheostomy), and found Resident 1 with no pulse. During a review of the Fire Call History (the logged record of 911 dispatch responses and pre-hospital medical treatments involving firefighter-paramedics), dated [DATE], the Fire Call History indicated on [DATE] the facility called 911 at 11:14 a.m. (five minutes after Resident 1 was found without a O2 sat and pulseless). During a review of Resident 1's Paramedic Run Sheet (the official prehospital medical record completed by emergency medical service providers that documents dispatch data, scene findings, patient assessments, treatments administered, vital signs and hospital handoff), dated [DATE], the (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Paramedic Run Sheet indicated Paramedics arrived at Resident 1 at 11:24 a.m. (10 minutes after they were called by the facility and 15 minutes after Resident 1 was found without an O2 sat level and pulseless). The Paramedic took over CPR and termination of resuscitation occurred at 11:45 a.m. During an interview on [DATE] at 9:20 a.m., RT 1 stated on [DATE] in the morning (time unknown) her and Certified Nursing Assistant (CNA) 1 transported Resident 1 to the facility's shower room using Vent 2. After the shower, CNA 1 and CNA 2 put Resident 1 in her bed and she (RT 1) reconnected Resident 1 to Vent 1. RT 1 stated she went to lunch at approximately 10:40 a.m., and returned from lunch and entered Resident 1's room to administer a breathing treatment at approximately 11:08 a.m. RT 1 stated she noticed Resident 1 looked discolored (orange) and when she looked at Vent 1 everything was running OK but she observed Resident 1's eyes were not moving, so she suctioned her but Resident 1 had no gag reflex (an involuntary muscle contraction of the back of the throat). She then checked Resident 1's O2 sat and received an error reading. RT 1 stated she checked Resident 1's brachial pulse (a pulse felt on the inside of the upper arm) then checked her carotid pulse (a pulse felt on the side of the neck) but Resident 1 had no pulses. She ran to the doorway but did not see any staff, so she went to the nearest nursing station, which was approximately 20 feet away from Resident 1's room, found RT 2 and LVN 1 at the nursing station, and told them she needed help because Resident 1 was unresponsive. RT 1 stated she grabbed the crash cart, which was at the nursing station, and brought it to Resident 1's room. She removed the backboard (a hard board placed under a person during CPR to make chest compressions more effective) from the crash cart, returned to Resident 1 and checked Resident 1's radial pulse (a pulse felt at the wrist) but could not find a pulse. She then rechecked Resident 1's brachial pulse but could not find a pulse. She asked RT 2 to verify whether Resident 1 had a pulse, RT 2 after checking Resident 1 for a pulse, reported she could not find a pulse. LVN 1 flattened Resident 1's bed and deflated the air mattress (a mattress filled with air to help prevent skin injuries). LVN 2 arrived in the room, and she (LVN 2) and RT 2 helped her place the backboard under Resident 1, and RT 2 and LVN 1 began CPR. During an interview on [DATE] at 12 p.m., LVN 2 stated on [DATE], sometime before lunch (exact time unknown), he heard code blue (an emergency call indicating a person has stopped breathing or their heart has stopped) called to Resident 1's room. He went to Resident 1's room and on entering the room he noted Resident 1 was pale, in an upright position, and RT 1 was checking Resident 1's pulse. After staff flattened Resident 1's bed and deflated Resident 1's air mattress (a mattress filled with air to prevent skin injuries), he initiated CPR by doing chest compressions (pressing down on the chest to manually pump blood when the heart has stopped). During an interview on [DATE] at 8:48 a.m., RT 2 stated on [DATE], at approximately 11 a.m., while she was coming outside of another resident's room, she saw RT 1 come out of Resident 1's room and asked if Resident 1 was a full code (a medical instruction meaning all lifesaving measures, including CPR, should be used if the heart or breathing stops), and LVN 1 verbally confirmed that Resident 1 was a full code. RT 1 then reported that Resident 1 did not look well and motioned with her hands for staff to come into the room. RT 2 stated she ran into the hallway to grab the O2 cannister and brought it to Resident 1's room. When she entered Resident 1's room she noticed Resident 1 appeared pale, RT 1 reclined Resident 1's bed, then RT 2 stated she connected Resident 1's ventilator to the O2 and began by providing rescue breaths via bag-mask-valve (BVM) a handheld device used in emergency and clinical setting to manually push air or supplemental O2 into a patient's lungs). LVN 1 and LVN 2 followed her (RT 2) to Resident 1's room, and LVN 1 checked Resident 1's pulse before chest compressions were started. During an interview on [DATE] at 10:01 a.m., with RN 1, RN 1 stated she last saw Resident 1 at approximately 7:40 a.m. ([DATE]) and at approximately 10:20 a.m. she went to a meeting, and while she was in a (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meeting in the conference room LVN 1 called her on her personal cell phone at 11:11 a.m., and reported there was a code blue called on Resident 1. She went to Resident 1's room, saw that CPR was being performed on Resident 1 and left Resident 1's room to call 911. During an interview on [DATE] at 12:46 p.m., LVN 1 stated on [DATE], after 11 a.m. (exact time unknown), she was in the hallway preparing medications for another resident when she heard RT 1 shout is Resident 1 a full code? She responded, Yes. RT 1 then said that Resident 1 did not look good, she (LVN 1) went into Resident 1's room, she and RT 1 were the only staff present at that time. She noted Resident 1 appeared pale, she immediately checked Resident 1's radial and carotid pulses, at the same time, but there were no pulses. RT 1 was checking Resident 1's ventilator tubing (plastic tubes that connect a person to the breathing machine) and checking multiple pulse locations (carotid, radial and brachial sites) on Resident 1. RT 2 and LVN 2 then entered Resident 1's room. LVN 2 checked Resident 1's carotid pulse, and RT 2 checked another pulse location (not sure which site). LVN 1 stated she ran to the nursing station to call RN 1 and reported there was a code blue for Resident 1 and asked RN 1 to come quickly. During an interview on [DATE] at 10:11 a.m., the Director of Nursing (DON) stated when Resident 1 was found unresponsive it should have taken no longer than 10 seconds to check her carotid pulse, the carotid pulse should have been checked because it is the most dependable pulse source during an emergency and as soon as a pulse is not found, chest compressions should begin right away, and that additional verification of pulselessness was not needed because compressions quickly helps move oxygen through the body. The DON stated 911 should have been called immediately to allow paramedics to arrive as soon as possible to provide advanced cardiac life support (ACLS) a level of emergency medical care that includes special medications and equipment the facility does not use, waiting five minutes to call 911 was not reasonable because Resident 1 required advanced medical interventions that only paramedics could provide. During a review of facility's P/P titled Cardiopulmonary Resuscitation dated [DATE], the P/P indicated the facility's procedure for administering CPR shall incorporate the guidance from the current standards established by the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility Basic Life Support ([BLS] a set of emergency medical procedures designed to sustain life by maintaining breathing and circulation) training Material. During a review of the AHA Guidelines, dated 2025, the AHA Guidelines indicated for adult basic life support for healthcare professionals the algorithmic steps are: 1. Verify scene safety2. Check for responsiveness3. Shout for help nearby4. Activate the emergency response system5. Send someone to get the AED/defibrillator6. Look for breathing and check a pulse simultaneously within 10 seconds7. If there is no pulse start CPR by performing 30 compressions to 2-breath until an AED/defibrillator arrives8. Once AED arrives check for a shockable rhythm9. If not shockable resume CPR immediately for 2 minutes until prompted by the AED machine, and to continue until Advanced Life Support (ALS) professionals take over or the person starts to move. https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/algorithms		