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	08/23/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44423 Based on interview and record review, the facility failed to obtain an informed consent prior to the administration of psychotropic (medications that affect the mind, emotions, and behavior) medications for one out of three sample residents (Resident 16). This failure had the potential to place Resident 16 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication or intervention) related to psychotropic medication use. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a chronic mental illness that affects how a person thinks, feels, and behaves), altered mental status, and paranoid personality disorder (long-term pattern of distrust and suspicion of others without adequate reason). During a review of Resident 16's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 7/5/2024, the MDS indicated Resident 16's cognition (ability to think and reason) was intact. The MDS indicated Resident 16 required set up or assistance when performing activities of daily living (ADLs, daily self-care activities such as grooming, dressing, toileting, and personal hygiene) and required supervision when walking. During a review of Resident 16's History and Physical (H&P), dated 6/28/2024, the H&P indicated Resident 16 could make needs known but could not make medical decisions. During a review of Resident 16's Order Summary Report, dated 6/2024 to 8/2024, the report indicated Resident 16 was ordered the following psychotropic medications: - Quetiapine Fumarate (medication for schizophrenia, acute manic episodes, and mood disorders) Oral Tablet 400 milligram ([MG]- unit of measurement), mg by mouth two times a day for schizophrenia manifested by yelling outbursts from 6/30/2024 to 8/6/2024. - Lithium Carbonate (medication used to treat mood disorders) Extended-Release oral tablet 300mg, one tab by mouth three times a day for schizophrenia from 6/30/2024 to 8/6/2024. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Risperidone (a medication used to treat the symptoms of schizophrenia) Oral Tablet 2mg by mouth two times a day for schizophrenia manifested by yelling outbursts from 6/30/2024 to 7/29/2024. During a review of Resident 16's Medication Administration Record (MAR), dated 6/2024 to 8/2024, the MAR indicated Resident 16 was administered Quetiapine Fumarate Oral Tablet 400mg by mouth two times a day, Risperidone Oral Tablet 2mg by mouth two times a day, and Lithium Carbonate Extended-Release oral tablet 300mg one tab by mouth three times a day throughout the month of July 2024. During a review of Resident 16's Informed Consent Documentation, dated 8/8/2024, the document indicated consent for the use of Risperidone Oral Tablet 2mg, Lithium Carbonate Extended-Release oral tablet 300mg, and Quetiapine Fumarate Oral Tablet 400mg was obtained on 8/8/2024. During a concurrent interview and record review, on 8/22/2024, at 11:03 a.m., with the Medical Records Assistant (MRA), all of Resident 16's Informed Consent Documents, dated 2024, were reviewed. The MRA confirmed there were no other consents found in Resident 16's medical record before 8/8/2024. During a concurrent interview and record review on 8/22/2024, at 3:58 p.m., with Registered Nurse (RN) 1, Resident 16's Medication Administration Record (MAR), dated 6/2024 to 8/2024, was reviewed. The MAR indicated Resident 16 was administered Quetiapine Fumarate Oral Tablet 400mg by mouth two times a day, Risperidone Oral Tablet 2mg by mouth two times a day, and Lithium Carbonate Extended-Release oral tablet 300mg one tab by mouth three times a day throughout the month of July 2024. RN 1 stated licensed nurses should have verified that consent was obtained before the start of the psychotropic medications. During an interview, on 8/23/2024, at 1:09 p.m., with the Director of Nursing (DON), the DON stated that the process was to verify consent was obtained from the resident or the responsible party before the start of the administration of any psychotropic medications. The DON stated this process was important to verify that the responsible party of Resident 16 was educated and aware of the side effects of all the psychotropic medications. During a review of the facility's Policy and Procedure (P&P), titled, Behavior/ Psychoactive Medication Management, dated 1/25/2024, the P&P indicated the facility was to obtain a resident's written informed consent for treatment using psychotherapeutic drugs.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure an adaptive call light system was provided to a resident that was a quadriplegic (paralyzed on all limbs) and was completely dependent on staff to perform activities of daily living (ADLs, daily self-care activities such as grooming, dressing, toileting, and personal hygiene) for one out of out six sampled residents (Resident 101). This deficient practice had the potential for Resident 101 to be unable to make his needs known and placed Resident 101 at risk for harm. Findings: During a review of Resident 101's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included but not limited to quadriplegia, muscle weakness, and muscle wasting and atrophy. During a review of Resident 101's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 8/14/2024, the MDS indicated Resident 101's cognition (ability to think and reason) was impaired. The MDS indicated Resident 101 was dependent on staff to perform all activities of daily living. During a review of Resident 101's History and Physical (H&P), dated 8/10/2024, the H&P indicated Resident 101 was able to make decisions for activities of daily living. During a concurrent observation and interview, on 8/22/2024, at 10:51 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 101's call light was observed on the floor. LVN 3 stated the type of call light was not the type of call light needed for Resident 101 to use to call for assistance. LVN 3 stated Resident 101 should have been provided the call pad instead due to Resident 101's limited use of his extremities and hands. LVN 3 stated if a call light was not positioned within reach and if the call light was unable to be used by the resident, there was a possibility that Resident 101's needs may be missed. During a review of the facility's Policy and Procedure (P&P), titled, Communication Call System, dated 1/1/2012, the P&P indicated the facility was to provide an adaptive call bell provided to resident per resident's needs. During a review of the facility's Policy and Procedure (P&P), titled, Resident Rights- Quality of Life, dated 3/2017, the P&P indicated the facility was to ensure each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to provide one of one sampled resident (Resident 318) with the opportunity to choose a primary care physician (PCP) of his choice. This deficient practice violated Resident 318's right to choose a care provider of his choice and had the potential to affect Resident 318's quality of life, sense of self-worth and self-esteem. Findings: During a review of Resident 318's Admission Record, dated 8/23/2024, the admission record indicated Resident 318 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 318's diagnoses included pneumonia (a serious infection that affects the lungs, causing the air sacs to fill with fluid or pus), pulmonary edema (a condition where too much fluid builds up in the lungs, making it difficult to breathe), type 2 diabetes (a chronic condition resulting in high blood sugar levels), chronic obstructive pulmonary disease (a lung disease that causes breathing problems and restricted airflow), hyperlipidemia (excess fat in the blood), chronic kidney disease (CKD - a long-term condition that occurs when the kidneys are damaged and cannot filter blood properly), chronic pain (pain that is ongoing and usually lasts longer than six months), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 318's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 8/6/2024, the MDS indicated Resident 318 was able to make himself understood and able to understand others. The MDS indicated Resident 318 required partial assistance from another person to complete self-care activities. The MDS indicated Resident 318 required setup or clean up assistance with eating and required a helper for toileting and dependent on a helper for bathing. During a review of Resident 318's' History and Physical (H&P), dated 6/13/2024, the H&P indicated Resident 318 was seen by Primary Care Provider (PCP) 2. The H&P indicated Resident 318 could make needs known but could not make medical decisions. During a review of Resident 318's care plan titled Resident having delusional thoughts and verbalized [PCP 2] is not his doctor . initiated on 6/9/2023, revised on 3/21/2024 with a target date of 6/19/2024, the care plan indicated a goal of Resident 318 would have no delusional thoughts. The staff's interventions included to encourage to verbalize feelings and concerns. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/20/2024 at 11:38 a.m. with Resident 318, in Resident 318's room, Resident 318 was observed lying in bed. Resident 318 appeared extremely agitated (feeling or appearing troubled or nervous). Resident 318 shouted in a loud voice that he wanted PCP 2 changed to PCP 1. Resident 318 stated that he had spoken to the social services director (SSD) on several occasions, but the SSD refused to change his doctor to the one he preferred. Resident 318 stated that he was not receiving care because he did not have a doctor. Resident 318 became more agitated as he spoke. Resident 318, in a loud voice, stated, Don't you understand what I'm saying? Resident 318 stated he was currently assigned to PCP 2, even though he had repeatedly informed the SSD that he did not want PCP 2 as his doctor. Resident 318 stated as long as he had PCP 2 assigned as his doctor, he would consider himself as not having a doctor. Resident 318 stated that he knew his rights and he wanted to take the facility to court. Resident 318 stated that he had been complaining for two years and nothing gets done unless he yelled and raised his voice. Resident 318 stated he raised his voice at the SSD because he could not be nice anymore. During a concurrent interview and record review on 8/22/2024 at 1:01 p.m., with the SSD, Resident 318's medical record was reviewed. The SSD stated Resident 318's had behaviors of stating he did not have a doctor. The SSD stated that he had PCP 2 assigned as his primary care physician, but he had the right to choose a preferred PCP. The SSD stated Resident 318 did not want PCP 2 as his doctor because PCP 2 paralyzed him. The SSD stated she attempted to change Resident 318's PCP but because he did not complain to her again, she did not change the PCP. The SSD searched for documentation related to Resident 318's PCP change. The SSD stated that a care plan was initiated that indicated Resident 318 was having delusional thoughts about not having a doctor and not wanting PCP 2 as his doctor because he paralyzed his right arm. The SSD stated she was sure why she would not change Resident 318 PCP to his preferred doctor. The SSD stated she had not documented any notes regarding the request for a PCP change for Resident 318. The SSD stated she would have to find out why his PCP could not be changed. During an interview on 8/22/2024 at 4:33 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated in April 2024, Resident 318 verbalized that he did not want PCP 2 as his doctor. LVN 6 stated the facility offered a few doctors and Resident 318 chose PCP 3. LVN 6 stated PCP 3 was contacted the next day. LVN 6 stated PCP 3 informed her that he would consider seeing Resident 318, but he first needed to see Resident 318 in the facility. LVN 6 stated that Resident 318 was not notified that PCP 3 was requested as his new doctor. LVN 6 stated PCP 2 was not notified that Resident 318 requested another PCP. LVN 6 stated that PCP 2's Nurse Practitioner (NP, a Registered Nurse with advanced training) came to see Resident 318 on one occasion and Resident 318 did not seem to mind seeing the NP. LVN 6 stated PCP 3 never came to see Resident 318 in June 2024, however PCP 2 did show up in June 2024 to do Resident 318's H&P. LVN 6 stated that the facility failed to follow up and make sure Resident 318's PCP was changed as requested. LVN 6 stated that a resident had a right to choose their own doctor. LVN 6 stated by not changing Resident 318's doctor as he requested, it made Resident 318 feel like the facility was not honoring his wishes and it made him upset and have outbursts and interfered with his care. During an interview on 8/23/2024 at 2:03 p.m., with the Director of Nursing (DON), the DON stated Resident 318 was seeing PCP 2's NP and was not complaining because he was not seeing PCP 2. The DON stated Resident 318's doctor should have been changed because residents have a right to choose their doctor. The DON stated not changing Resident 318's doctor made him upset because the facility was not valuing Resident 318's choices. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights - Quality of Life, revised 1/1/2012, the P&P indicated the facility would promote and protect the rights of all residents at the facility. The P&P indicated residents have a right to choose a physician and treatment and participated in decisions and care planning.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to follow its policy and procedure for restraints for one out of one sampled resident's (Resident 52) by failing to: 1. Ensure the order for a right-hand mitten restraint (purposely limiting or obstructing the freedom of a person's bodily movement) specified a duration (time frame) of use for Resident 52, as specified in the facility's policy. 2. Ensure documentation was performed for the assessment of Resident 52's circulation, sensation, movement, and skin integrity for the duration of Resident 52's use of a right-hand mitten restraint. These deficient practices had the potential to cause unnecessary use of a mitten restraint, skin breakdown and impaired circulation (movement of blood throughout the body) for Resident 52. Findings: During an observation, on 8/21/2024, at 10:57 a.m., Resident 52 had a right-hand mitten restraint in place. During a review of Resident 52's Admission Record, the Admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included tracheostomy (a surgical procedure that creates an opening in the neck and into the windpipe to help a person breathe), functional quadriplegia (a condition that causes complete immobility due to severe disability or frailty from another medical condition, without physical injury or damage to the spinal cord), traumatic subdural hemorrhage (brain bleed). During a review of Resident 52's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 7/31/2024, the MDS indicated Resident 52's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 52 was entirely dependent on staff to perform activities of daily living (ADLs, daily self-care activities such as grooming, dressing, toileting, and personal hygiene). During a review of Resident 52's Order Summary, dated 8/23/2024, the order summary indicated Resident 52 order was may apply right-hand mitten due to manipulating or pulling medical tubing since 5/25/2023. The restraint order did not specify an end date or a discontinued date. The Order Summary did not indicate there was an order to assess or monitor Resident 52's circulation, sensation, movement, and skin integrity as indicated in the facility policy. During a review of Resident 52's Medication Administration Record (MAR), dated 5/2023 to 8/22/2024, no documentation was indicated to demonstrate an assessment was performed for Resident 52's circulation, movement, sensation, and skin breakdown. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 8/23/2024, at 1:11p.m., with the Director of (DON), the facility's policy and procedure (P&P) titled, Restraints, dated 1/25/2024, was reviewed. The P&P indicated the was facility was to ensure restraint orders specified the period the restraint was used. The P&P also indicated the facility was to ensure the observation of the skin and circulation, and the release of the restraint every two hours. The DON stated Resident 52's current restraint order did not specify the length or duration of use. The DON stated Resident 52's MAR did not adequately reflect documentation to indicate Resident 52's skin, circulation, sensation, and motion was assessed every two hours throughout the time period the restraint order was active. The DON stated that no end date for Resident 52's restraint order and lack of assessment documentation did not align with the facility's policy for restraints. The DON stated this had the potential to lead to the continued unnecessary use of the restraint and unmonitored skin breakdown, or loss of circulation and sensation for Resident 52. During a review of the facility's P&P dated 1/25/2024, titled Restraints, the P&P indicated to ensure restraint orders specified the period the restraint was used. The P&P also indicated the facility was to ensure the observation of the skin and circulation, and the release of the restraint every two hours.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to revise the nutritional care plan, perform ongoing assessments, and revise the interventions for one of one sampled resident (Resident 317) after returning to the facility from the general acute care hospital (GACH) due to failure to thrive (features of weight loss, exhaustion, weakness, and decreased physical activity) and decreased oral intake. This deficient practice placed Resident 317 at risk for altered nutritional status and weight loss. Findings: a. During a review of Resident 317's Admission Record, dated 8/23/2024, the admission record indicated Resident 317 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 317's diagnoses included anorexia nervosa (an eating disorder that involves severe calorie restriction and often a low body weight), protein-calorie malnutrition (a condition that occurs when someone doesn't get enough protein, calories, and other nutrients), anemia (a blood disorder that occurs when the body does not have enough healthy red blood cells), adult failure to thrive (a syndrome of decline that includes weight loss, poor nutrition, inactivity, and decreased appetite), vitamin D (an essential vitamin that helps with bone development and can also help with energy levels and mood) deficiency (a condition where the body doesn't have enough vitamin D to stay healthy), chronic kidney disease (CKD - a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), dementia (a loss of brain function that affects a person's ability to think, remember, and reason), depression (a mental health condition that can cause a persistent feeling of sadness and loss of interest in activities). During a review of Resident 317's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 8/6/2024, the MDS indicated Resident 317 was moderately impaired (decision poor; cues/supervision required) with cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 317 required setup or clean up assistance with eating and required a helper for all efforts related to toileting and bathing. The MDS indicated Resident 317 weighed 126 pounds (lbs.) and was on a therapeutic (a meal plan prescribed by a physician that controls the intake of certain foods or nutrients) diet. During a review of Resident 317's History and Physical (H&P), dated 11/13/2023, the H&P indicated Resident 317 was not competent to understand his medical condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 317's care plan titled Resident at risk for complications regarding nutritional problems or potential nutritional problems related to multiple comorbidities (the condition of having two or more diseases at the same time), malnutrition (a serious health condition that occurs when a person's diet doesn't provide the right amount of nutrients or calories, or when the body can't absorb nutrients from food), adult failure to thrive, and poor oral intake, initiated on 9/1/2023 and revised on 6/7/2024, the care plan indicated Resident 317 would maintain adequate nutritional status as evidenced by maintaining weight within ideal body weight range, no signs and symptoms of malnutrition, and consuming at least (70%) of at least two meals daily. The staff interventions included to explain and reinforce to Resident 317 the importance of maintaining the diet ordered, encourage the resident to comply and explain the consequences of refusal, risk factors of malnutrition, provide and serve supplements as ordered, provide, serve diet as ordered and monitor intake and record every meal. The staff interventions also included to monitor/document/report to the physician, as needed, any signs and symptoms of malnutrition and refusals to eat. During a review of Resident 317's Nutritional Risk Assessment, dated 9/11/2023, the nutritional assessment indicated Resident 317 weighed 128 lbs on 9/1/2023. The nutritional assessment indicated Resident 317 was at risk for altered nutrition status and weight changes related to current diagnoses and variable oral intakes. The nutritional assessment indicated a regular diet with no added salt, current supplement of Vitamin D2 (supplement). The nutritional assessment indicated a goal was to maintain current body weight with no significant weight changes and to tolerate oral diet with intakes greater than 75%. During a review of Resident 317's Nutritional Risk Assessment, dated 5/3/2024, the nutritional assessment indicated Resident 317 weighed 124 lbs. on 5/3/2024. The nutritional assessment indicated Resident 317's goal weight was noted between 125 to 135 lbs. The nutritional assessment indicated Resident 317 had variable oral intake. The nutritional assessment indicated the RD recommended adding nutrients to support nutritional status. The nutritional assessment indicated the RD's recommendation for Resident 317 was to maintain an adequate nutritional status as evidenced by no significant weight changes for one, three and six months, oral intake greater than 50% for meals for three months for two or more meals and adequate protein. The nutritional assessment indicated nutritional interventions of snacks at 10 a.m. and at bedtime, Med Plus 2.0 60 cubic centimeters (cc, unit of measurement) (a nutritional shake that provides calories and protein as a supplement drink for people who are at high risk of malnutrition) three times a day, a daily multivitamin and a regular diet with no added salt and thin consistency. During a review of Resident 317's Nursing Progress Note dated 8/2/2024 at 8:41 a.m., the nursing note indicated Resident 317 was observed not eating breakfast and lunch but offered with nourishment and graham crackers. During a review of Resident 317's Nursing Progress Note titled Change In Condition/s (CIC), dated 8/5/2024 at 11:28 a.m., the CIC nursing progress note indicated during nursing observations, and evaluation, Resident 317 was noted to have poor oral intake, refused to eat breakfast, lunch and dinner, and refused supplements. The CIC indicated Resident 317 would be transferred to a general acute care hospital (GACH) for further evaluation due to failure to thrive. During a review of Resident 317's CIC Evaluation dated 8/5/2024 at 11:29 a.m., the CIC indicated Resident 317's CIC was due to poor oral intake. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 317's Nursing Progress Note dated 8/17/2024 at 9:38 p.m., the nursing progress note indicated Resident 317 returned to the facility from the GACH. During a review of Resident 317's Nutritional care plan for the month of August 2024, the nutritional care plan did not indicate a revised care plan for Resident 317's change in condition (CIC) related to poor oral intake on 8/5/2024. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/22/2024 for a Registered Dietician (RD, a health professional who specializes in nutrition and diet) consult for poor meal intake and weight loss. The order indicated a onetime only order for seven days with an end date of 8/29/2024. During an interview on 8/20/2024 at 12:37 p.m. with Resident 67 (Resident 317's roommate), Resident 67 stated he observed Resident 317 had not eaten for ten days. Resident 67 stated nurses would deliver Resident 317's tray and would come back to pick up the same tray that was untouched and uneaten by Resident 317. Resident 67 stated nurses were not reporting the uneaten meals and just coming back to pick up the uneaten trays. Resident 67 stated he decided to report the uneaten meals of Resident 317 to a nurse and that is when Resident 317 was sent to the hospital for evaluation. During a concurrent observation, interview and record review on 8/20/2024 at 1 p.m. with Certified Nursing Assistant (CNA) 2, observed CNA 5 picking up Resident 317's lunch tray and putting it on the meal cart. CNA 2 stated Resident 317 had eaten only 30% of his lunch. CNA 2 stated if a resident has eaten less than 50% of their meal, the charge nurse must be notified. CNA 2 stated she would also record the percentage of meals eaten in the resident's chart. Resident 317's meal record was observed. There was no record of Resident 317's breakfast noted on the meal record. CNA 2 stated Resident 317 had only eaten 30% for breakfast and lunch. CNA 2 stated she had not charted Resident 317's breakfast and did not notify the nurse that he had only eaten 30% because she had gotten too busy. CNA 2 she should have charted the breakfast earlier and notified the nurse. CNA 2 stated 30% is not enough for Resident 317 so she will make sure to notify the charge nurse and get Resident 317 a meal replacement. CNA 2 stated, It is important to report Resident 317's meals to the charge nurse when they are eating less than 50% because Resident 317 can lose weight and have skin breakdown. During an observation on 8/21/2024 at 12:46 p.m. in Resident 317's room, Resident 317 was complaining that he had not yet received his lunch and he was hungry. During an observation on 8/21/2024 at 1:55 p.m., observed CNA 3 placing Resident 317's lunch tray at his bedside table. During an observation and interview on 8/21/2024 at 2:17 p.m., observed Resident 317's tray had been picked up from his bedside table. CNA 3 stated Resident 317 had eaten 30% of his lunch. CNA 3 stated she was unable to show the tray of Resident 317 because he didn't have a meal ticket on his lunch tray, so she does not remember which one was his tray. CNA 3 stated Resident 317 should have had a tray ticket on his lunch tray to ensure he was getting the correct meal. CNA 3 stated that since he only ate 30% of his lunch, she would notify the charge nurse and make sure that he gets a Boost (a brand of nutritional drinks that are intended to supplement a balanced diet and provide extra nutrition). CNA 3 walked away stating she would look for the charge nurse to report Resident 317's intake and get him a Boost supplement. (continued on next page)

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	055077	A. Building B. Wing	08/23/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/21/2024 at 2:20 p.m. with Occupational Therapist (OT, healthcare professionals who help people with injuries, illnesses, or disabilities develop, recover, or maintain skills to live independently) 1 and CNA 3, observed OT 1 hand a resident's tray with no tray ticket to CNA 3. OT 1 stated to CNA 3 that the resident was finished eating. CNA 3 took the tray from OT 1 and placed it on the meal cart. OT 1 stated that she should not have taken the tray from the resident because there was no way for the CNA and charge nurse assigned to that resident to know how much the resident had eaten. CNA 3 stated, I am just collecting the tray from because it was handed to me. That resident is not my patient. OT 1 stated, I will go let the charge nurse know that I picked up the resident's tray. During an interview on 8/22/2024 at 2:33 p.m., with CNA 4, CNA 4 stated Resident 317 at 75% of his breakfast and 50 % of his lunch. CNA 4 stated the charge nurse was notified Resident only ate 50% of his lunch and he gave Resident 317 a Boost. During a concurrent interview and record review on 8/23/2024 at 8:32 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 317's CIC dated 8/5/2024 was reviewed. LVN 4 stated on 8/5/2024 a CIC was done for Resident 317 due to refusal to eat breakfast, lunch, dinner or take supplements that day and Resident 317 was transferred out to the GACH for further evaluation. LVN 4 stated if a resident missed one or two meals, the doctor must be notified. LVN 4 stated 50% or less of meals eaten should be reported to the doctor. LVN 4 stated if a resident was not eating or something had changed with the resident's appetite or the resident had a decrease of 2lbs or more in weight, the CNAs would notify the charge nurse of the decrease in appetite and the restorative nursing aide (RNA, a CNA with special training in rehabilitation skills and techniques) would notify charge nurse of the change in weight. LVN 4 stated that the charge nurse would then notify the physician and document a CIC. LVN 4 stated upon review of Resident 317's medical record, there was no order for Boost or any other supplemental shakes for the Resident 317. LVN 4 stated if Resident 317 was receiving supplemental shakes, there must be a doctor's order before giving the shakes to the resident. LVN 4 stated he had not given Resident 317 any type of supplemental shake because supplemental shakes were not ordered for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 8/23/2024 at 8:58 a.m. with LVN 2, Resident 317's Nutrition Report, for the months of July 2024 and August 2024 was reviewed. LVN 2 stated according to Resident 317's nutrition report, Resident 317 refused his snack and lunch on 7/26/2024, but there was no meal documented for dinner on that day. LVN 2 stated there was no documentation in the nurse's notes of any interventions or that the physician was notified. LVN 2 stated on 7/29/2024, Resident 317 ate 50% or less for breakfast and lunch but no interventions were documented in the nurse's notes. LVN 2 stated that on 7/31/2024, Resident 317 ate 50% or less for breakfast, 25% or less for lunch and refused dinner. LVN 2 stated that no interventions were documented in the nursing progress notes. LVN 2 stated on 8/1/2024, Resident 317's dinner was not recorded. LVN 2 on 8/2/2024, stated Resident 317 refused breakfast and lunch and ate less than 50% of his dinner. LVN 2 stated the nursing note progress note on 8/2/2024, indicated Resident 317 was observed not eating breakfast and lunch but offered nourishment and graham cracker. LVN 2 stated on 8/3/2024, Resident 317's breakfast was noted as not applicable and his dinner that day indicated he ate 50% or less of his meal but not documentation was noted in the nursing progress notes. LVN 2 stated only one meal was documented on 8/4/2024. LVN 2 admitted that Resident's meals were charted inconsistently. LVN 2 stated the CNAs are supposed report meals that are less than 50% or meals that were not eaten by the resident to the charge nurse so that the physician can be called to get supplements and an RD consult. LVN 2 stated she was the charge nurse for Resident 317 on 8/20/2024. LVN 2 stated according to Resident 317's nutritional notes, he ate less than 50% for both breakfast and lunch on that day. LVN 2 stated the CNA did not report his meals to her for breakfast or lunch. LVN 2 stated the CNA should have reported his meal intake of less than 50% and if she had known she would have offered Resident 317 an alternative meal, called the doctor and documented in the nursing progress notes. LVN 2 stated that Resident 317 did not have a doctor's order for supplemental shakes, and she did not offer a supplemental shake to Resident 317 on 8/20/2024. LVN 2 agreed that it was also her responsibility to check Resident 317's meal intake during her shift to ensure he was provided with enough nourishment for the day. LVN 2 stated that Resident 317 could lose energy and fail to thrive because of the inconsistent record of his meal intakes and not notifying the doctor when the resident was eating less than 50% or refusing meals. During an interview on 8/23/2024 at 2:55 p.m., with the Director of Nursing (DON), the DON stated the CNAs would chart the intake for all residents' meals. The DON stated there should not be missing charting. The DON stated the CNAs should have notified the charge nurse to see if Resident 317 could get an alternative meal or assess Resident 317 to see if something else was going on that caused his decrease in appetite. The DON stated the charge nurse should be notified and a CIC should have been done for Resident 317. The DON stated that Resident 317 should have been placed on a feeding program a weight management program and an RD consult. The DON stated that Resident 317 could have lost weight and ended up back in the acute care hospital. The DON stated, We needed to do something for him when he returned from the hospital. b. During a review of Resident 67's Admission Record, the admission record indicated Resident 67 was initially admitted to the facility on [DATE], and last admitted on [DATE]. Resident 67's diagnoses included Type 2 diabetes mellitus (abnormal blood sugar) and CKD. During a review of Resident 67's H&P, dated 8/21/2024, the H&P indicated Resident 67 could make needs known but could not make medical decisions. During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67 had no cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight Nutrition Status/Nursing Manual - Dietary & Dining, revised on 11/26/2022, the P&P indicated the facility will work to maintain an acceptable nutritional status for resident by: 1. Assessing the resident's nutrition status and the factors that put the resident at risk of not maintaining acceptable parameter of nutrition status. 2. Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs. 3. Defining and implementing interventions for maintain or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice. 4. Monitoring and evaluating the resident's response, or the lack of response to interventions. 5. Revising or discontinuing the approaches as appropriate or justifying the continuation of current approaches.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview, and record review, the facility failed to ensure: 1. Medication was not left at the bedside for one out of 5 sampled residents (Resident 24). This deficient practice had the potential to result in medication errors and having another resident possibly take the medication. Findings: During a review of Resident 24's face sheet, the face sheet indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 24's diagnoses included restlessness and agitation (a feeling of severe restlessness, crankiness, or uneasiness), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and mood disorder (a mental health condition that primarily affects your emotional state). During a review of Resident 24's Minimum Data Set Assessment (MDS- a standardized assessment and care screening tool), dated 8/7/2024, the MDS indicated Resident 24 was cognitively intact (ability to think and reason). The MDS indicated Resident 24 required partial assistance and supervision with transferring, dressing, and grooming from nursing staff. During an interview, on 8/22/2024 at 12:28 p.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated while passing evening medication on 8/12/2024, Resident 24 became verbally aggressive with her, stating to leave the medication at his bedside table. LVN 5 stated she complied with leaving the medication at Resident 24's bedside due to being afraid and uncomfortable with Resident 24's behavior. LVN 5 stated medications were not to be left at a resident's bedside table. LVN 5 stated the risk of leaving medication at the bedside could result in medication error or another resident taking the medication. During an interview, on 8/22/2024, at 3:47 p.m., with Registered Nurse 1 (RN 1), RN 1 stated medications were not to be left at a resident's bedside. RN 1 stated licensed nurses were to remain with a resident to ensure the resident took the medication. RN 1 stated the risk of leaving medication at the bedside could result in other residents taking the medication, adverse reactions, medication errors, and possible illness. During an interview, on 8/24/2024, at 11:15 a.m., with the Director of Nursing (DON), the DON stated licensed nurses were to remain at the bedside while the resident took the medication. The DON stated licensed nurses were not allowed to leave any medication at a resident's bedside for any reason. The DON stated the risk of leaving medication at the bedside could result in the resident not taking the medication and medication errors. During a review of the facility's policy and procedures (P&P), titled Medication-Management, dated 1/1/2012, the P&P indicated medications must be given to a resident by the licensed nurse preparing the medication.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to meet and maintain the nutritional needs of one of three sampled residents (Resident 317) by: 1. Failing to follow the nutritional care plan and interventions. 2. Failing to consistently record Resident 317's oral intake for every meal. 3. Failing to follow the recommendations of the registered dietician (RD, a health professional who specializes in nutrition and diet) to add nutritional shakes three times a day during med pass. This deficient practice placed Resident 317 at risk for altered nutritional status and weight loss. Findings: a. During a review of Resident 317's Admission Record, dated 8/23/2024, the admission record indicated Resident 317 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 317's diagnoses included anorexia nervosa (an eating disorder that involves severe calorie restriction and often a low body weight), protein-calorie malnutrition (a condition that occurs when someone doesn't get enough protein, calories, and other nutrients), anemia (a blood disorder that occurs when the body does not have enough healthy red blood cells), adult failure to thrive (a syndrome of decline that includes weight loss, poor nutrition, inactivity, and decreased appetite), vitamin D (an essential vitamin that helps with bone development and can also help with energy levels and mood) deficiency (a condition where the body doesn't have enough vitamin D to stay healthy), chronic kidney disease (CKD - a long-term condition that occurs when the kidneys are damaged and cannot filter blood properly), dementia (a loss of brain function that affects a person's ability to think, remember, and reason), depression (a mental health condition that can cause a persistent feeling of sadness and loss of interest in activities). During a review of Resident 317's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 8/6/2024, the MDS indicated Resident 317 was moderately impaired (decision poor; cues/supervision required) with cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 317 required setup or clean up assistance with eating and required a helper for all efforts related to toileting and bathing. The MDS indicated Resident 317 weighed 126 pounds (lbs) and was on a therapeutic diet (diet ordered by a physician as part of a treatment of disease or clinical condition). During a review of Resident 317's' History and Physical (H&P), dated 11/13/2023, the H&P indicated Resident 317 was not competent to understand his medical condition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 317's care plan titled Resident at risk for complications regarding nutritional problems or potential nutritional problems related to multiple comorbidities (the condition of having two or more diseases at the same time), malnutrition (a serious health condition that occurs when a person's diet doesn't provide the right amount of nutrients or calories, or when the body cannot absorb nutrients from food), adult failure to thrive, and poor oral intake, initiated on 9/1/2023 and revised on 6/7/2024, the care plan indicated Resident 317 would maintain adequate nutritional status as evidenced by maintaining weight within ideal body weight range, no signs and symptoms of malnutrition, and consuming at least (70%) of at least two meals daily. The staff interventions included to explain and reinforce to the resident the importance of maintaining the diet ordered, encourage resident to comply and explain consequences of refusal, risk factors of malnutrition, provide and serve supplements as ordered, provide, serve diet as ordered and monitor intake and record every meal. The staff interventions included to monitor/document/report to medical doctor as needed any signs and symptoms of malnutrition and refusing to eat. During a review of Resident 317's Nutritional Risk Assessment, dated 9/11/2023, the nutritional assessment indicated Resident 317 weighed 128 lbs on 9/1/2023. The nutritional assessment indicated Resident 317 was at risk for altered nutrition status and weight changes related to current diagnoses and variable oral intakes. The nutritional assessment indicated a regular diet with no added salt. Current supplement of Vitamin D2. The nutritional assessment indicated a goal to maintain current body weight with no significant weight changes and to tolerate oral diet with intakes greater than 75%. During a review of Resident 317's Nutritional Risk Assessment, dated 5/3/2024, the nutritional assessment indicated Resident 317 weighed 124 lbs. on 5/3/2024. The nutritional assessment indicated Resident 317's goal weight was noted between 125 to 135 lbs. The nutritional assessment indicated Resident 317 had variable oral intake. The nutritional assessment indicated the RD recommended adding nutrients to support nutritional status. The nutritional assessment indicated the RD's recommendation for Resident 317 was to maintain an adequate nutritional status as evidenced by no significant weight changes for one, three and six months, oral intake greater than 50% for meals for three months for two or more meals and adequate protein. The nutritional assessment indicated nutritional interventions of snacks at 10 a.m. and at bedtime, Med Plus 2.0 (a nutritional shake that provides calories and protein as a supplement drink for people who are at high risk of malnutrition) 60 cubic centimeters (cc, unit of measurement) three times a day, a daily multivitamin and a regular diet with no added salt and thin consistency. During a review of Resident 317's Nursing Note dated 8/2/2024 at 8:41 a.m., the nursing note indicated Resident 317 was observed not eating breakfast and lunch but offered with nourishment and graham crackers. During a review of Resident 317's Nursing Progress Note titled Change In Condition/s (CIC) dated 8/5/2024 at 11:28 a.m., the CIC nursing progress note indicated during nursing observations, and evaluation, Resident 317 was noted to have poor oral intake, refused to eat breakfast, lunch and dinner and refused supplements. The CIC indicated Resident 317 would be transferred to a general acute care hospital (GACH) for further evaluation due to failure to thrive. During a review of Resident 317's CIC Evaluation dated 8/5/2024 at 11:29 a.m., the CIC indicated Resident 317's CIC was due to poor oral intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 317's Nursing Progress Note dated 8/17/2024 at 9:38 p.m., the nursing progress noted indicated Resident 317 returned to the facility from the GACH. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/17/2024 for a Renal Diet (a diet that limits certain nutrients and fluids to help maintain the balance of electrolytes, minerals, and fluids in the body) with 80 milligrams (MG) protein, regular texture, and regular/thin consistency. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/18/2024 for Ergocalciferol (Vitamin D2 - a form of vitamin D that helps the body use calcium and phosphorus to make strong bones and teeth) Oral Capsule 1.25 MG. The order indicated to give one capsule by mouth one time a day every Friday for supplement. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/17/2024 for Ferrous Sulfate (a type of iron that's used to treat and prevent iron deficiency anemia) Tablet 325 MG. The order indicated to give one tablet by mouth one time a day for supplement. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/17/2024 for Folic Acid (a B vitamin that helps the body make healthy red blood cells) Oral Tablet 1 MG. The order indicated to give one tablet by mouth one time a day for supplement. During a review of Resident 317's Order Summary Report, dated 8/23/2024, the order summary report indicated an active order dated 8/22/2024 for an RD consult for poor meal intake and weight loss. The order indicated a onetime only order for seven days with an end date of 8/29/2024. During a concurrent observation, interview and record review on 8/20/2024 at 1 p.m. with Certified Nursing Assistant (CNA) 2, observed CNA 5 picking up Resident 317's lunch tray and putting it on the meal cart. CNA 2 stated Resident 317 had eaten only 30% of his lunch. CNA 2 stated if a resident had eaten less than 50% of their meal, the charge nurse must be notified. CNA 2 stated she would also record the percentage of meals eaten in the resident's chart. Resident 317's meal record was observed. There was no record of Resident 317's breakfast noted on the meal record. CNA 2 stated Resident 317 had only eaten 30% for breakfast and lunch. CNA 2 stated she had not charted Resident 317's breakfast and did not notify the nurse that he had only eaten 30% because she had gotten too busy. CNA 2 she should have charted the breakfast earlier and notified the nurse. CNA 2 stated 30% is not enough for Resident 317 so she would make sure to notify the charge nurse and get Resident 317 a meal replacement. CNA 2 stated, It is important to report Resident 317's meals to the charge nurse when they are eating less than 50% because Resident 317 could lose weight and have skin breakdown. During an observation on 8/21/2024 at 12:46 p.m. in Resident 317's room, Resident 317 was complaining that he had not yet received his lunch and he was hungry. During an observation on 8/21/2024 at 1:55 p.m., observed CNA 3 placing Resident 317's lunch trat at his bedside table. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/21/2024 at 2:17 p.m., observed Resident 317's tray had been picked up from his bedside table. CNA 3 stated Resident 317 had eaten 30% of his lunch. CNA 3 stated she was unable to show the tray of Resident 317 because he didn't have a meal ticket on his lunch tray, so she does not remember which one was his tray. CNA 3 stated Resident 317 should have had a tray ticket on his lunch tray to ensure he was getting the correct meal. CNA 3 stated that since he only ate 30% of his lunch, she would notify the charge nurse and make sure that he gets a Boost (a brand of nutritional drinks that are intended to supplement a balanced diet and provide extra nutrition). CNA 3 walked away stating she would look for the charge nurse to report Resident 317's intake and get him a Boost supplement. During an observation and interview on 8/21/2024 at 2:20 p.m. with occupational therapist (OT) and CNA 3, observed OT hand a resident's tray with no tray ticket to CNA 3. OT stated to CNA 3 that the resident was finished eating. CNA 3 took the tray from OT and placed it on the meal cart. OT stated that she should not have taken the tray from the resident because there was no way for the CNA and charge nurse assigned to that resident to know how much the resident had eaten. CNA 3 stated I am just collecting the tray from OT because it was handed to me. That resident is not my patient. OT stated, I will go let the charge nurse know that I picked up the resident's tray. During an interview on 8/22/2024 at 2:33 p.m., with CNA 4, CNA 4 stated Resident 317 at 75% of his breakfast and 50 % of his lunch. CNA 4 stated the charge nurse was notified Resident only ate 50% of his lunch and he gave Resident 317 a Boost. During a concurrent interview and record review on 8/23/2024 at 8:32 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 317's chart was reviewed. LVN 4 stated on 8/5/2024 a CIC was done for Resident 317 due to refusal to eat breakfast, lunch, dinner or take supplements that day and Resident 317 was transferred out to an acute care hospital for further evaluation. LVN 4 stated if a resident missed one or two meals, the doctor must be notified. LVN 4 stated 50% or less of meals eaten should be reported to the doctor. LVN 4 stated if a resident was not eating or something had changed with the resident's appetite or the resident had a decrease of 2lbs or more in weight, the CNAs would notify the charge nurse of the decrease in appetite and the RNA would notify charge nurse of the change in weight. LVN 4 stated that the charge nurse would then notify the physician and document a CIC. LVN 4 stated upon review of Resident 317's medical record, there was no order for Boost or any other supplemental shakes for the Resident 317. LVN 4 stated if Resident 317 was receiving supplemental shakes, there must be a doctor's order before giving the shakes to the resident. LVN 4 stated he had not given Resident 317 any type of supplemental shake because supplemental shakes were not ordered for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 8/23/2024 at 8:58 a.m. with LVN 2, Resident 317's medical record was reviewed. LVN 2 stated according to Resident 317's nutrition report, Resident 317 refused his snack and lunch on 7/26/2024 but there was no meal documented for dinner on that day. LVN 2 stated there was no documentation in the nurse's notes of any interventions or that the physician was notified. LVN 2 stated on 7/29/2024 Resident 317 ate 50% or less for breakfast and lunch but no interventions were documented in the nurse's notes. LVN 2 stated that on 7/31/2024 Resident 317 ate 50% or less for breakfast, 25% or less for lunch and refused dinner. LVN 2 stated that no interventions were documented in the nursing progress notes. LVN 2 stated on 8/1/2024 Resident 317's dinner was not recorded. LVN 2 on 8/2/2024 stated Resident 317 refused breakfast and lunch and ate less than 50% of his dinner. LVN 2 stated the nursing note progress note on 8/2/2024 indicated Resident 317 was observed not eating breakfast and lunch but offered nourishment and graham cracker. LVN 2 stated on 8/3/2024 Resident 317's breakfast was noted as not applicable and his dinner that day indicated he ate 50% or less of his meal but not documentation was noted in the nursing progress notes. LVN 2 stated only one meal was documented on 8/4/2024. LVN 2 admitted that Resident's meals were charted inconsistently. LVN 2 stated the CNAs are supposed report meals that are less than 50% or meals that were not eaten by the resident to the charge nurse so that the physician could be called to get supplements and an RD consult. LVN 2 stated she was the charge nurse for Resident 317 on 8/20/2024. LVN 2 stated according to Resident 317's nutritional notes, he ate less than 50% for both breakfast and lunch on that day. LVN 2 stated the CNA did not report his meals to her for breakfast or lunch. LVN 2 stated the CNA should have reported his meal intake of less than 50% and if she had known she would have offered Resident 317 an alternative meal, called the doctor and documented in the nursing progress notes. LVN 2 stated that Resident 317 did not have a doctor's order for supplemental shakes, and she did not offer a supplemental shake to Resident 317 on 8/20/2024. LVN 2 agreed that it was also her responsibility to check Resident 317's meal intake during her shift to ensure he was provided with enough nourishment for the day. LVN 2 stated that Resident 317 could lose energy and fail to thrive because of the inconsistent record of his meal intakes and not notifying the doctor when the resident was eating less than 50% or refusing meals. During an interview on 8/23/2024 at 2:55 p.m., with the Director of Nursing (DON), the DON stated the CNAs would chart the intake for all residents' meals. The DON stated there should not be missing charting. The DON stated the CNAs should have notified the charge nurse to see if Resident 317 could get an alternative meal or assess Resident 317 to see if something else was going on that caused his decrease in appetite. The DON stated the charge nurse should be notified and a CIC should have been done for Resident 317. The DON stated that Resident 317 should have been placed on a feeding program a weight management program and an RD consult. The DON stated that Resident 317 could have lost weight and ended up back in the acute care hospital. The DON stated, We needed to do something for him when he returned from the hospital. b. During an interview on 8/20/2024 at 12:37 p.m. with Resident 67 (Resident 317's roommate), Resident 67 stated he observed Resident 317 had not eaten for ten days. Resident 67 stated nurses would deliver Resident 317's tray and would come back to pick up the same tray that was untouched and uneaten by Resident 317. Resident 67 stated nurses were not reporting the uneaten meals and just coming back to pick up the uneaten trays. Resident 67 stated he decided to report the uneaten meals of Resident 317 to a nurse and that was when Resident 317 was sent to the hospital for evaluation. During a review of Resident 67's Admission Record, the admission record indicated Resident 67 was initially admitted to the facility on [DATE], and last admitted on [DATE]. Resident 67's diagnoses included Type 2 diabetes mellitus (abnormal blood sugar) and CKD. (continued on next page)

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	08/23/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 67's H&P, dated 8/21/2024, the H&P indicated Resident 67 could make needs known but could not make medical decisions. During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67 had no cognitive impairment. During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight Nutrition Status/Nursing Manual - Dietary & Dining, revised on 11/26/2022, the P&P indicated the facility would work to maintain an acceptable nutritional status for resident by: 1. Assessing the resident's nutrition status and the factors that put the resident at risk of not maintaining acceptable parameter of nutrition status. 2. Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs. 3. Defining and implementing interventions for maintain or improving nutritional status that ae consistent with resident needs, goals, and recognized standards of practice. 4. Monitoring and evaluating the resident's response, or the lack of response to interventions. 5. Revising or discontinuing the approaches as appropriate or justifying the continuation of current approaches.

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	055077	A. Building B. Wing	08/23/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview, and record review, the facility failed to follow a physician order for oxygen administration for one out of 5 sampled residents (Resident 48). This deficient practice had the potential to cause breathing complications as a result of being under oxygenated. Findings: During a review of Resident 48's Admission Record (face sheet), the admission record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 48's diagnoses included acute kidney failure (a condition in which the kidney), paraplegia (paralysis [inability to move] of the legs), atelectasis (complete or partial collapse of a lung or a section of a lung) and urinary tract infection (an illness in any part of the urinary tract, the system of organs that makes urine). During a review of Resident 48's Minimum Data Set Assessment, dated 5/3/2024, (MDS- a standardized assessment and care screening tool), the MDS indicated Resident 48 was moderately cognitively impaired (ability to think and reason). The MDS indicated Resident 48 was dependent on staff with transferring, dressing, and grooming. During an observation, on 8/20/2024, at 9:53 a.m., Resident 48 was observed receiving oxygen via nasal cannula (a device that delivers extra oxygen through a tube and into your nose) at 2.5 liters (L, unit of measurement) per minute. During a review of Resident 48's physician orders, on 8/20/2024, at 11:30 a.m., Resident 48's physician order for oxygen administration stated Resident 48 was to be administered 4 liters of oxygen via nasal cannula. During an observation, on 8/22/2024, at 8:44 a.m., Resident 48 was observed receiving oxygen via nasal cannula at 2.5 liter per minute. During a concurrent observation and interview, on 8/22/2024 at 9:15 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 observed Resident 48's oxygen tank administering 2.5 liters per minute. LVN 4 verified the physician order and stated Resident 48 should had been receiving 4 liters per minute. LVN 4 stated the risk of administering oxygen at a lower rate than ordered could result in low oxygen levels, complications such as weakness and/or shortness of breath. During an interview, on 8/22/2024, at 3:47 p.m., with Registered Nurse 1 (RN 1), RN 1 stated Resident 48 had an order to receive oxygen at 4 liters per minute. RN 1 stated the risk of not administering oxygen at the order rate could result in under oxygenating a resident, shortness of breath, and oxygen desaturation. (continued on next page)

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	055077	A. Building B. Wing	08/23/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 8/24/2024, at 11:15 a.m., with the Director of Nursing (DON), the DON observed Resident 48 was receiving 2.5 liters per minute. The DON acknowledged the physician order stating Resident 48 was to receive 4 liters per minute. The DON stated the risk of administering oxygen at a lower rate than ordered could result in a resident receiving an insufficient amount of oxygen. The DON stated, It can also cause a lower oxygen saturation (the amount of oxygen in our blood) level. During a review of the facility's policy and procedures (P&P), titled Oxygen Therapy, revised 11/2017, the P&P indicated to administer oxygen per physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure the adequate storage and disposal of controlled (a drug that is secured under lock and key and has the potential to be misused), and non-controlled medications when the facility failed to ensure the following: 1. Ensure Hydrocodone and Acetaminophen (a controlled medication, used to treat severe pain) 5-325 milligram ([MG]-a unit of measurement) was properly disposed and wasted, and not kept in the medication bubble pack (a special packaging for resident medications) sealed with paper tape located in Medication Cart 2 . 2. Ensure a liquid bottle of Docusate Sodium (stool softener) was disposed in the proper medication disposal bin receptacle in Medication room [ROOM NUMBER]. 3. Ensure the door to Medication room [ROOM NUMBER] was locked and secured. These deficient practices had the potential for medication errors, drug diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use), and accidental consumption to occur. Findings: 1. During a concurrent observation and interview on 8/21/2024 at 2:42 p.m., with Licensed Vocational Nurse (LVN) 2, Medication Cart 2 was inspected. One bubble of the bubble pack of Hydrocodone and Acetaminophen (a controlled medication) 5-325mg tab was taped with white paper tape. LVN 2 stated that the medication was a narcotic and should have been wasted to avoid drug diversion or the possible administration of the medication. 2. During a concurrent observation and interview on 8/21/2024 at 3:05 p.m., with Registered Nurse (RN) 2, Medication room [ROOM NUMBER] was inspected. One bottle of Docusate Sodium Liquid was observed in the regular trash can. The bottle had liquid remaining. RN 2 stated that liquid medications should be disposed in the proper medication disposal bin. RN 2 stated that if medications were disposed in a regular trash can, it could increase the likelihood that the medication would be consumed or administered to another resident. 3. During an observation on 8/21/2024, at 3:10 p.m., the door of Medication room [ROOM NUMBER] was unlocked and unsecured. The door was able to be pushed open. During a concurrent observation and interview on 8/22/2024 at 9:50 a.m., with RN 2, the door of Medication room [ROOM NUMBER] was inspected. The medication room door was left unlocked and unsecured when the door was pushed open. RN 2 stated that the licensed nurses may not have noticed that the medication room door did not shut completely. RN 2 stated that it was important to keep the medication room closed to avoid drug diversion and accidental consumption of the controlled and non-controlled medications housed in the medication room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P), titled, Medication Storage Within the Facility, dated 8/2014, the P&P indicated the facility was to ensure that when a dose of a controlled medication is removed from the container, and it was not placed back in the container. The P&P indicated that the controlled medications was destroyed in the presence of two licensed nurses, and the disposal was documented on the accountability record on the line representing that dose. The same process applied to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason. During a review of the facility's Policy and Procedure (P&P), titled, Disposal Of Medications And Medication-Related Supplies, dated 10/2017, the P&P indicated the facility was to ensure all medications were placed in the proper waste container per facility policy.

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	055077	A. Building B. Wing	08/23/2024

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to follow up on the missing/lost dentures for one out of six sampled residents (Resident 6). This deficient practice had the potential for Resident 6 to exhibit weight loss due to limited food choices and choking. Findings: During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 6's diagnoses included malnutrition (lack of sufficient nutrients in the body), dysphagia (trouble swallowing), and muscle weakness. During a review of Resident 6's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 8/15/2024, the MDS indicated Resident 6's cognition (ability to think and reason) was slightly impaired. The MDS indicated Resident 6 required partial assistance (when a person receives hands-on help with an activity but is still able to participate to some degree) with eating and performing oral hygiene, and was dependent on staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 6 had a swallowing disorder in which Resident 6 would hold food in Resident 6's mouth or cheeks. The MDS indicated Resident 6 had no teeth. During an observation and interview, on 8/20/2024, at 2:09 p.m., with Resident 6, in Resident 6's room, Resident 6 was observed with no dentures or teeth in her mouth. Resident 6 stated that she wished she could enjoy eating bacon again, but the facility told her she could not because she did not have teeth to chew it. Resident 6 stated that she had been eating without her dentures because they have been broken for about a year now. Resident 6 stated that she was unsure why the facility had not helped her get new dentures. During an observation and interview, on 8/21/2024, at 9:50 a.m., with Resident 6, Resident 6 was observed eating scrambled eggs and squared pieces of ham. Resident 6 stated she was not chewing the ham and she usually swallows her food whole without her dentures. During a concurrent record review and interview, on 8/22/2024, at 11:48 a.m., with the Social Service Director (SSD), Resident 6's Dental Exam Forms and SSD Progress Notes, dated 2023 to 2024 were reviewed. The dental exam forms indicated Resident 6 reported that her dentures were lost or missing, and the treatment recommendation was for the facility to seek authorization for new dentures. The progress notes indicated that there were no follow up actions from the SSD after 8/30/2023. The SSD stated that the entire Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) was responsible for reviewing the recommendations of the dentist based on the Dental Exam Form. The SSD stated it was important to follow up on lost dentures so that Resident 6 could eat properly. The SSD stated that a referral should have been placed immediately, and staff should have looked for the dentures. The SSD stated if Resident 6 did not have her dentures, then it could negatively affect her daily living, and possibly lead to weight loss because it limits his or her food choices. (continued on next page)

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	055077	A. Building B. Wing	08/23/2024

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/23/2024, at 1:06 p.m. with the Director of Nursing (DON), the DON stated that if a resident were to report missing, damaged, or lost dentures, the facility should have followed up and the SSD would have been expected to look for the dentures or follow recommendations set forth by the dentist. The DON stated that if Resident 6 did not have her dentures, then Resident 6 would not be able to eat properly and would be at risk for choking and weight loss. During a review of the facility's Policy and Procedure (P&P), titled, Oral Healthcare and Dental Services, dated 7/14/2014, the P&P indicated the facility was to ensure all dental appointments are made in a timely manner and a delay in referrals would be documented. The P&P indicated residents with lost or damaged dentures are referred to a dentist within three business days. During a review of the facility's P&P, titled, Resident Rights- Quality of Life, dated 3/2017, the P&P indicated the facility was to ensure each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. 48131

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 46832 Based on observation and interview, the facility failed to ensure: 1. One of four of the facility's trash dumpsters was not overfilled with an open lid. This deficient practice had the potential to result in pest and vermin infestation. Findings: During a concurrent observation and interview upon the initial kitchen inspection, on 8/20/2024 at 8:55 a.m., with the Dietary Supervisor (DS), one of the facility's four outside trash dumpsters was observed to be overfilled with trash with the trash lid open. The DS stated all trash from the kitchen should have been able to fit in the dumpster containers with closed lids. The DS confirmed the trash dumpster was overfilled and the lid was opened. The DS stated the risk of having an opened trash dumpster overfilled with trash could result in an infestation of pests and vermin. During a review of the facility's policy and procedures (P&P), titled Waste Management, revised 11/2017, the P&P indicated food waste will be placed in covered garbage and trash cans.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure effective infection prevention practices were implemented for a resident with suspected scabies (a contagious skin condition caused by the human itch mite) for one out of three sampled residents (Resident 8) when the facility failed to: 1. Obtain an order and perform a scabies skin scraping (a diagnostic procedure for scabies that involves scraping a suspected lesion with a scalpel blade or glass slide to collect a sample that can be examined under a microscope for mites or eggs) for Resident 8 in a timely manner and before treatment for scabies was administered. 2. Ensure Resident 8 remained in contact isolation (a set of measures used to prevent the spread of infectious agents that can be transmitted through direct or indirect contact with a patient or their environment) during the course of Resident 8's second round of treatment for suspected scabies and before Resident 8's second skin scraping. These deficient practices had the potential to cause the spread of a scabies outbreak throughout the facility, placing all residents, staff, and visitors at risk. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE]. Resident 8's diagnoses included metabolic encephalopathy (a group of brain disorders), contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the right and left knee, and spinal enthesopathy (a disorder that affects the areas where tendons, ligaments, or muscles attach to bones in the spine). During a review of Resident 8's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 7/19/2024, the MDS indicated Resident 8's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 8 was entirely dependent on staff to perform activities of daily living (ADLs, daily self-care activities such as grooming, dressing, toileting, and personal hygiene). During an observation, on 8/21/2024, at 10:00 a.m., Resident 8 was observed in Room A with two roommates. Room A was marked by an Enhanced Barrier Precaution (EBP, an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission infectious organisms) sign. During a review of the facility's Infection Prevention and Control Surveillance Log, dated 7/2024, the log indicated Resident 8 had been treated with Permethrin External Cream (a skin cream that treats scabies) 5 percent (%). The log indicated Resident 8's symptoms started on 7/10/2024, the infection was acquired within the facility, and that Resident 8 was placed on contact isolation from 7/10/2024 to 7/11/2024. The log indicated Resident 8 exhibited symptoms that started on 7/26/2024 and was treated with Permethrin 5% (for a second time) and Ivermectin (an anti-parasite medication). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's Order Summary Report, dated 6/1/2024 to 8/2024, the Order Summary Report indicated Resident 8 was ordered to have a skin scraping to rule out dermatitis, unspecified (a general term that describes inflammation of the skin) on 7/29/2024. Resident 8 was also ordered Permethrin External Cream 5 % to be applied to from the neck to the soles of the feet topically every evening shift at 9 p. m. every Thursday for dermatitis unspecified prophylaxis (prevent or control the spread of an infection or disease) on 7/10/2024 to 7/12/2024; 7/24/2024 to 7/29/2024; and 8/5/2024 to 9/5/2024 (end date). The order summary also indicated Resident 8 was ordered Ivermectin Oral Tablet 3 milligrams ([MG]- unit of measurement) every Monday for dermatitis unspecified for four weeks until finished (8/26/2024). The report indicated Resident 8 was ordered to remain on contact isolation for two days (7/10/2024 to 7/12/2024). During a review of Resident 8's Nursing Progress Note, dated 8/5/2024, the note indicated Resident 8 was to have a skin scraping performed on 8/28/2024. During a review of Resident 8's Scabies Examination Report, reported on 8/1/2024, the report indicated the examination was negative. During an interview, on 8/23/2024, at 10:00a.m., with Physician 1, Physician 1 stated the normal process to treat a resident with a suspected case of scabies was to isolate and place the resident on contact precautions. Physician 1 stated the resident should have a skin scraping performed immediately to rule out scabies well before treatment has started. Physician 1 stated to verify if treatment was effective, another scraping should have been performed afterwards. Physician 1 stated Resident 8 should have had a skin scraping performed immediately after she had exhibited symptoms (on 7/10/2024). Physician 1 stated Resident 8 should have remained in contact isolation during treatment, especially because another round of treatment was ordered, and because Resident 8 had not yet had her second skin scraping performed. During an interview, on 8/23/2024, at 12:02 p.m. with the Infection Prevention Nurse (IPN), the IPN stated she did not obtain an order for a skin scraping examination because the IPN wanted to determine whether or not Resident 8's treatment was effective before the skin scraping was performed. During an interview, on 8/23/2024, at 1:20 p.m., with the Director of Nursing, the DON stated the facility should have obtained an order for a skin scraping immediately after the resident exhibited symptoms. The DON also stated that Resident 8 should have been placed in a contact isolation room and have contact precautions in place. The DON stated that there was a potential for scabies to spread to the other residents, staff and throughout the facility. During a review of the facility's Policy and Procedure (P&P), titled, Infection Control, dated 1/1/2012, the P&P indicated the facility was to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the facility's P&P, titled, Prevention and Management of Scabies (undated), the P&P indicated the facility was to establish contact isolation during the treatment period and 24 hours after. During a review of the facility's P&P, titled, Resident Isolation- Initiating Transmission Based Precautions (undated), the P&P indicated the facility was to ensure the use of transmission-based precautions when a resident has a communicable infectious disease.