

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

Printed: 07/18/2026
Form Approved OMB
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 08/15/2025
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.			
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure two out of five sampled residents (Resident 62 ,Resident 101 and Resident 80) received care and services to promote wound healing and to prevent new pressure injuries (PI: localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) from occurring by: 1. Failing to initiate a wound treatment for Resident 62 when a change of condition (COC) was identified as a Stage III pressure injury (injury that extends through the skin into deeper tissue and fat)on 6/26/2025. 2. Failing to follow and implement the plan of care for repositioning every two (2) hours for Resident 62, Resident 101 and Resident 80. 3. Failing to provide offloading measures (refer to strategies used to reduce or redistribute pressure on specific parts of the body to prevent pressure injuries), such as a low air loss mattress (LAL- minimizing or removing weight to help prevent and heal ulcer) upon identification of the pressure ulcer in Resident 62 and Resident 101. 4. Failing to ensure the Registered Dietitian ([RD] nutrition specialist) reassessed and implemented nutritional interventions for Resident 62 and Resident 101. 5. Failing to ensure the interdisciplinary team (IDT: group of healthcare teams consisting of various specialties that share and combine their knowledge and information to create the best possible care plan for the resident) met to discuss and develop appropriate wound healing interventions for Resident 62 and Resident 101. These deficient practices resulted in Resident 62, Resident 101's and Resident 80 preventable PI. Resident 62's right buttock redness progressed to a Stage III PI on 6/26/2025 with measurements of 2 centimeter (cm: unit of length) by (x) 2 cm (width) x 0.2 cm (depth). Resident 101 skin redness on the coccyx (tailbone area) identified on 6/25/2025 progressed to an unstageable PI (base of the wound is unable to be determined due to the base of the wound covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) on 6/26/2025, measuring 0.5 cm long x 0.5cm width x 0 cm depth. Resident 101's PI was reclassified as a stage III PI, measuring 1 cm length x 1 cm width x 0.1 cm depth with 100 percent (%) granulation (new, red, bumpy, and moist connective tissue fills the wound bed).Findings: a. During a review of Resident 62's admission Record (Face Sheet), the admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), type II diabetes mellitus (DM: a chronic disease that affects how the body processes sugar), and dementia (a progressive state of decline in mental abilities). During a review of Resident 62's Minimum Data Set (MDS: a resident assessment tool), dated 6/25/2025, the MDS indicated Resident 62 was cognitively (mental action or process of acquiring knowledge and understanding ability) severely impaired. The MDS indicated Resident 62 was dependent on staff for chair/bed-to-chair transfer, shower transfer, toileting hygiene, bathing, upper (waist above) and lower (waist below) body dress, required moderate assistance (provides less than (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 0686 Level of Harm - Actual harm Residents Affected - Few	half the effort) for oral hygiene, and required supervision for eating. The MDS indicated Resident 62 was at risk for developing pressure ulcers/injuries with no indication of an active pressure ulcer/injury. The MDS indicated Resident 62 had other skin issues of Moisture Associated Skin Damage (MASD: moisture associated skin damage caused from prolonged exposure to moisture) and had skin and ulcer/injury treatments to provide nutrition or hydration intervention to manage skin problems and applications of ointments/medications other than to feet. During a record review of Resident 62's COC dated 6/25/2025 at 1:11 p.m., the COC indicated a Certified Nursing Assistant (CNA) was changing and cleaning Resident 62 when there was redness on the right buttocks and reported to Treatment Nurse 2 (TXN 2) The recommendation was to follow the facility protocol treatment for redness. During a record review of Resident 62's Braden Scale for Predicting Pressure Ulcer Risk evaluation (a tool designed to help healthcare providers assess the resident's risk for developing pressure injury), dated 6/25/2025 timed 3:08 pm, the Braden Scale indicated Resident 62 was at high risk (score range 10 to 12) for developing pressure ulcers with a score of 12. During a record review of Resident 62's wound assessment and plan visit dated 6/26/2025 indicated as Stage III pressure injury measured 2.0 cm length x 2.5 cm width x 0.2 cm depth. During a review of Resident 62's progress note dated 6/26/2025 timed 3:09 pm, the progress note indicated Resident 62's right buttock redness was re-classified to Stage III PI. The wound was acquired in-house (within the facility) on 6/26/2025 and the PI was staged by the Physician Assistant (PA) with measurements of 2 cm x 2 cm x 0.2 cm. The primary dressing is MediHoney gel with secondary dressing to offload pressure. During a record review of Resident 62's Treatment Administration Record (TAR: document that indicates the administration of treatments for residents) for 6/2025, the TAR indicated starting on 6/28/2025, for Right buttock PI: cleanse with NS (normal saline solution-a mixture of water and salt concentrate of 0.9 percent [%]), pat dry, apply Medical Honey (MediHoney: promote healing in wounds by creating a moist environment offering antimicrobial and anti-inflammatory effect) gel, cover with specialized foam dressing, every day shift for 30 days. During a review of Resident 62's care plan (CP) untitled dated 6/30/2025, the CP indicated stage III right buttocks PI with interventions to keep skin clean and dry, and moisturized, turn/reposition resident every 2 hours, and administer treatment per Medical Doctor (MD) order initiated on 6/30/2025. During a record review of the Nutrition/Dietary Note dated 7/22/2025 at 10:34 am, the nutrition/dietary note indicated Resident 62 had a Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) PI on the right buttocks with measurements of 1 cm x 1 cm x 0.1 cm. During an observation on 8/14/2025 at 8:52 am, Resident 62 was observed lying on her left side on a low air loss mattress (LAL) with a position pillow to her mid-back and buttocks area. Three linen sheets were placed under Resident 62's buttocks reducing air circulation. During an observation on 8/14/2025 at 9:50 am, Resident 62 was observed lying on her left side in the same position with the position pillow to the right buttock and three sheets underneath resident's (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the family and involved them (the family) in the IDT, and the IDT team created the plan of care. The DON stted that the RD should be involved within 48 hours, and the care plan should be initiated and reflect the intended care. DON stated the IDT should meet with the residents within 72 hours if there is a COC. The DON stated care plan interventions should include repositioning the resident every 2 hours, providing low air loss(LAL) mattress, and avoiding putting on multiple sheets to the mattress, as it defeats the purpose of the airflow mattress. During the interview on 8/15/2025 at 2:12 pm, the DON stated a pressure injury is preventable if the residents care plans and assessments are done accordingly. The DON stated the facility cannot prove that Resident 62 was being repositioned since they do not document repositioning in the POC. The DON stated Resident 62 does not have a reassessment Braden Scale when it should have been done the day the pressure injury was discovered (on 6/26/2025). The DON stated when a pressure injury was identified on 6/26/2025 . The DON stated the low air loss mattress was ordered on 7/22/2025, almost a month after the identification of pressure injury. During a review of the facility's Policy & Procedure (P&P) titled, Skin Integrity Management revised on 6/27/2024, the P&P indicated facility will identify, evaluate, and intervene to prevent further pressure injury and/or heal pressure ulcers and any other skin integrity conditions. B. During a review of Resident 101's Face Sheet, the Face Sheet indicated Resident 101 was initially admitted to the facility 4/7/2020 and was readmitted on [DATE] with diagnoses of hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infection (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left dominant side, g-tube, and type II DM. During a review of Resident 101's History and Physical (H&P), dated 12/22/2024, the H&P indicated Resident 101 does not have the capacity to understand and make decisions. During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 101's cognition was severely impaired. The MDS indicated Resident 101 is dependent on all aspects of performing activities of daily living (ADLs: activities such as bathing, dressing, personal/oral hygiene, and toileting). The MDS indicated Resident 101 has impairment on both sides of the upper and lower extremity. The MDS indicated Resident 101 had a Stage III PI with skin and ulcer/injury treatments of pressure reducing devices for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer/injury care. During a record review of Resident 101's COC dated 6/25/2025 at 11 am, the COC indicated TXN noted redness on Resident 101's coccyx. (commonly referred to as the tailbone) initial treatment was rendered, and the Nurse Practitioner (NP) was notified. During a review of Resident 101's COC dated 6/26/2025, the COC indicated upon reassessment with the wound care team and PA, the previously classified Stage I (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness)PI (appears as redness caused by prolonged pressure, often on a bony area) on the coccyx was classified as unstageable PI on 6/26/2025. During a review of Resident 101's CP titled Unstageable Pressure Injury dated 6/29/2025, the CP indicated repositioned Resident 101 every two hours. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to implement infection control policies when the facility failed to: a. Keep the laundry's designated clean area clean without staff's personal items and food. b. Implement the water management plan (comprehensive plan aimed to prevent waterborne illnesses by controlling germs in the water) by not checking control measures (things the facility will do in the building water system to limit growth and spread of Legionella [bacteria that can cause Legionnaire's Disease - serious type of infection in the lungs]). c. Implement the water management plan by not testing one of one resident (Resident 9) who had pneumonia (an infection/inflammation in the lungs) for Legionella. These deficient practices had the potential to result in the spread of infections in the facility and cause undue harm to all the residents' health and well-being in the facility. Findings: a. During a concurrent observation and interview on 8/14/2025 at 12:19 p.m. with the Housekeeping Laundry Supervisor (HLS), in laundry clean linen area, multiple personal items of staff were observed on the shelves. The HLS stated there were staff two black bags, two left-over water bottles, one toaster connected to an electric outlet, one bottle of sauce, multiple crackers, and 2 plastic bags of staff's food in the clean laundry area. The HLS stated those items should not be in the clean laundry linen area, and it could affect infection control practice in the facility. During a concurrent interview and record review with the HLS, the facility's policy and procedure (P&P) titled, Laundry Services, revised 1/2012 was reviewed. The P&P indicated on-site laundry services is maintained in a clean and sanitary condition. The HLS stated the laundry's designated clean linen area should be kept clean, it was not clean when staff had their personal items including food kept in the laundry's clean linen room. During an interview on 8/14/2025 at 3:04 p.m. with the Director of Nursing (DON), the DON stated, laundry's designated clean linen room should be kept clean without food or laundry staff's personal items for infection control. b. During a review of the facility's Water management Plan and Legionella Prevention Program, dated 4/11/2023, the plan indicated the team has developed control measures for the facility. and the plan would indicate and perform the following: 1) Measure cold water temperatures every month and keep the temperatures between 77 degrees Fahrenheit to 113 degrees Fahrenheit. 2) Disinfectant Residual (amount of disinfectant available in the water to kill germs) Measurement every month and keep disinfectant residual of at least 0.1 milligrams/ Liter (unit of measurement) of free chlorine (chemical element used as a disinfectant in water purification) to prevent Legionella growth. 3) Measure the levels of hydrogen in the water ([pH] measure of how acidic/basic water is) every month. During an interview on 8/14/2025 at 2:48 p.m. with the Director of Maintenance (DM), the DM stated the facility does not check the pH of the water, chlorine levels of the water, or the cold-water temperature monthly. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. During a record review of Resident 9's admission Record, the admission Record indicated the facility originally admitted Resident 9 on 4/24/2024 and recently readmitted Resident 9 on 1/25/2025, with a diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange) and dependence on ventilator (a medical device to help support or replace breathing). During a review of Resident 9's Minimum Data Set ([MDS] a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 9's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 9 was dependent on staff with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 9's Change of Condition Evaluation, dated 7/15/2025 at 11:15 p.m., the evaluation indicated Resident 9 was sent out to the general acute care hospital (GACH) 1 for altered mental status and Resident 9 was readmitted back to the facility with a diagnosis of pneumonia. During a concurrent interview and record review on 8/14/2025 at 3 p.m. with the Infection Prevention Nurse (IPN), the facility's Water management Plan for the Prevention of Waterborne Pathogens, revised 6/5/2025, was reviewed. The IPN stated the facility does not check the pH of the water, chlorine levels of the water, and the cold-water temperature monthly. The IPN stated Resident 9 had Healthcare-Acquired ([HAI] infection contracted in the facility) pneumonia on 7/15/2025 and was not tested for legionella and he should have been tested as indicated in the plan. During an interview on 8/15/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated the facility needed to implement the Water management Plan to prevent a Legionella outbreak. During a review of the facility's Water management Plan and Legionella Prevention Program, dated 4/11/2023, the plan indicated IPN will conduct surveillance (monitoring)for cases of HAI pneumonia developed after two calendar days of admission to the facility. The plan indicated upon detection of HAI pneumonia, the IPN will notify the medical director to obtain testing affected residents for Legionella.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement two of three residents' care plan (Resident 8 and 62) when: a. The facility failed to ensure the Registered Dietician ([RD] food and nutrition expert) evaluated Resident 8. b. The facility failed to ensure Resident 62 and Resident 101 was repositioned every two hours. These deficient practices had the potential to result in poor quality of care and a delay in care and services. Findings: a. During a review of Resident 8's admission Record, the admission record indicated Resident 8 was originally admitted to the facility on [DATE] with diagnosis including protein calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and a gastrostomy tube ([G-tube]a surgical opening fitted with a device to allow tube feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 8's Minimum Data Set ([MDS] a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 8's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 8 was dependent (helper does all the effort to complete the task) with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 8/14/2025 at 1:20 p.m. with Registered Nurse (RN) 1, Resident 8's Care Plan Report and RD notes were reviewed. The care plan report indicated Resident 8 had a G-tube and was receiving tube feeding. The care plan goal, revised 8/11/2025, indicated the RD will evaluate quarterly and as needed to monitor caloric intake, and make recommendations for changes to tube feeding as needed. Resident 8's RD notes indicated the last time Resident was evaluated by the RD was on 3/12/2025. RN 1 stated the care plan indicated RD should evaluate Resident 8 quarterly and the last time the RD evaluated Resident 8 was 3/12/2025 and the RD should have evaluated Resident 8 in June 2025 to check if Resident 8 was doing well nutritionally. During an interview on 8/15/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated the resident care plans should be implemented as indicated and the RD should evaluate residents as indicated. During a review of the facility's policy and procedure (P&P) titled, P-NP04 Person Centered Care Planning, revised 4/24/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. B . During a review of Resident 62's admission Record , the admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), type II diabetes mellitus (DM: a chronic disease that affects how the body processes sugar), and dementia (a progressive state of decline in mental abilities).During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 was cognitively severely impaired. The MDS indicated Resident 62 was dependent on staff for chair/bed-to-chair transfer, shower transfer, toileting hygiene, bathing, upper (waist above) and lower (waist below) body dress, required moderate assistance (provides less than half the effort) for oral hygiene, and required supervision for eating. The MDS indicated Resident 62 was at risk for developing pressure ulcers/injuries with no indication of an active pressure ulcer/injury. The MDS indicated Resident 62 had other skin issues of Moisture Associated Skin Damage (MASD: moisture associated skin damage caused from prolonged exposure to moisture) and had skin and ulcer/injury treatments to provide nutrition or hydration intervention to manage skin problems and applications of ointments/medications other than to feet.During a review (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident 101's Face Sheet, the Face Sheet indicated Resident 101 was initially admitted to the facility 4/7/2020 and was readmitted on [DATE] with diagnoses of hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infection (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left dominant side, g-tube, and Type II DM. During a review of Resident 101's H&P dated 12/22/2024, the H&P indicated Resident 101 does not have the capacity to understand and make decisions. During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 101's cognition was severely impaired. The MDS indicated Resident 101 is dependent on all aspects of performing activities of daily living (ADLs: activities such as bathing, dressing, personal/oral hygiene, and toileting). The MDS indicated Resident 101 has impairment on both sides of the upper and lower extremity. The MDS indicated Resident 101 had a Stage III PI with skin and ulcer/injury treatments of pressure reducing devices for bed, nutrition or hydration intervention to manage skin problems, and pressure ulcer/injury care. During a concurrent interview and record review on 8/15/2025 at 8:21 am, Certified Nursing Assistant 4 (CNA 4) stated staff should reposition residents every 2 hours. CNA 4 stated that there was no documentation of repositioning on paper or in the POC. During a concurrent observation, interview and record review on 8/14/2025 at 3:49 pm with LVN 4, LVN 4 stated LVN 4 stated it was important to chart, including Change of Condition (COC), Care plan, and labs and indicated residents should be repositioned every 2 hours. LVN 4 stated CNAs were responsible for documentation of Resident 62's and Resident 101's repositioning in PCC. During a review of Resident 62's care plan (CP) untitled dated 6/30/2025, the CP indicated stage III right buttocks PI with interventions to keep skin clean and dry, and moisturized, turn/reposition resident every 2 hours, and administer treatment per Medical Doctor (MD) order initiated on 6/30/2025. During a review of Resident 101's CP titled Unstageable Pressure Injury dated 6/29/2025, the CP indicated repositioned Resident 101 every two hours. During a review of Resident 62's ADL (ADLs- routine tasks/activities such as bathing, dressing, repositioning, and toileting a person performs daily to care for themselves) dated 6/1/2025-8/15/2025, indicated no records of repositioning Resident 62 every 2 hours as stated in the Resident 62's CP. During an interview on 8/15/2025 at 2:12 pm with DON, DON stated care plan interventions like repositioning the resident every 2 hours and providing low air loss (LAL) mattress, and avoiding putting on multiple sheets to the mattress as it defeats the purpose of the airflow mattress. DON stated a pressure ulcer is preventable if the residents' careplans and assessments were done accordingly. DON stated the facility cannot prove that Resident 62 was being repositioned and Resident 101 has some gaps since they do not document repositioning in POC. During a review of the facility's policy and procedure (P&P) titled, P&P Skin Integrity management, revised as of 6/27/2024, the P&P indicated a Residents' CP must be reviewed & updated as necessary, and treatments including repositioning to prevent pressure ulcers will be documented in Residents' medical Record.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its residents with or without limited range of motion (ROM - movement of the joints) received appropriate treatment and services to increase, prevent, or maintain the ROM mobility for four of seven residents (Resident 7 , Resident 8, Resident 90, and Resident 54) with physician's orders for Restorative Nursing Assistant (RNA) exercises. These deficient practices placed residents with orders for RNA exercises at risk for decline in physical function and at risk for contractures. Findings: a. During a review of Resident 7's admission Record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), rotator cuff (group of muscles and tendons that surround the shoulder joint) tear or rupture of right shoulder, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left knee, right and left hand, and left elbow. During a review of Resident 7's history and physical (H&P) dated 1/20/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set ([MDS] a resident assessment tool) dated 5/20/2025, the MDS indicated Resident 7's cognition (ability to think and reason) was intact. The MDS indicated Resident 7 was dependent on all aspects of activities of daily living (ADLs: activities such as bathing, dressing, personal/oral hygiene, and toileting). The MDS indicated Resident 7 had impairments on both the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 7's Order summary as of 8/14/2025, the summary indicated RNA program was ordered on 2/5/2025 for passive ROM (PROM: requires no effort from the resident a machine or person is moving the joints) exercises on both lower extremities (LE) once a day five (5) times a week as tolerated and splinting (medical device to immobilize part of the body) on both knees up to four (4) hours as tolerated 5 times a week. The order summary additionally indicated RNA program ordered on 2/6/2025 indicated the following: -RNA to apply Bilateral Wrist-Hand-Finger Orthosis ([WHFO] device designed to support and immobilize the wrist, hand, and fingers) resting hand splints for up to 4 hours as tolerated 5 times a week -RNA to apply left (L) elbow extension splint for up to 4 hours as tolerated 5 times a week -RNA to perform bilateral upper extremity (BUE) PROM five times a week or as tolerated During an interview on 8/15/2025 at 10:02 a.m. with the Director of Rehab (DOR), the DOR stated splints are applied for contracture management and prevention. The DOR stated residents cannot miss a day without splints. During a concurrent interview and record review on 8/15/2025 at 11:21 a.m., with RNA 1, Resident 7's Restorative Administration Record for May 2025 and August 2025 were reviewed. RNA 1 stated the sections that are left blank may have been her day off. RNA 1 stated she works regularly with (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 7 and indicated she works 4 days and is off two (2) days and indicated Resident 7 did not receive RNA services as ordered. During an interview on 8/15/2025 at 2:05 p.m., with the DON, the DON stated RNA is important for Residents to maintain their mobility and prevent decline. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, revised 9/19/2019, the P&P indicated the program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The RNA documents the frequency of the program, the amount of time the resident spent in the activity and their tolerance to the program. b. During a review of Resident 8's admission Record, the admission record indicated Resident 8 was originally admitted to the facility on [DATE] with diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), dependent on ventilator (a medical device to help support or replace breathing), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and unspecified joint contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 8's Minimum Data Set ([MDS] a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 8's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 8 was dependent (helper does all the effort to complete the task) with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 8's Order summary as of 8/14/2025, the summary indicated, ordered 4/2025, RNA program for the following: a. Apply Bilateral elbow extension splints (medical device to immobilize part of the body) for up to four hours, every day 5 times a week or as tolerated every dayshift (7 a.m. to 3 p.m.) b. Apply Bilateral Wrist-Hand-Finger Orthosis ([WHFO] device designed to support and immobilize the wrist, hand, and fingers) splint with hand grasp for up to four hours every day 5 times a week or as tolerated every dayshift. c. Apply bilateral lower extremities (BLE) Pressure Relief Ankle Foot Orthoses ([PRAFOs] devices used to relieve pressure on the foot and ankle) for up to four hours every day 5 times a week or as tolerated. d. Perform Passive Range of Motion ([PROM] exercises where a helper or device moves the patient's joints through their full range of motion without resident effort) to BLE and bilateral upper extremities (BUE) every day 5 times a week or as tolerated. During a concurrent interview and record review on 8/14/2025 at 11:20 a.m., with Registered Nurse 2 (RN 2), Resident 8's Restorative Administration Record, 7/2025 and 8/2025 were reviewed. The record indicated Resident 8 did not receive RNA services as five times a week or as tolerated. RN 2 stated Resident 8 did not use BUE elbow splints from 7/2025 to 8/2025 and Resident 8 did not receive PROM for BLE as ordered. RN 2 stated Resident 8 did not wear bilateral WHFO and bilateral (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PRAFOs five times a week. RN 2 stated Resident 8 did not receive PROM to BUE five times a week. c. During a review of Resident 90's admission Record, the admission record indicated Resident 90 was originally admitted to the facility on [DATE] with diagnosis including chronic respiratory failure, dependent on a ventilator, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) affecting left non-dominant side. During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90's cognition was severely impaired. The MDS indicated Resident 90 was dependent on staff with all ADLs. During a review of Resident 90's Orders, printed 8/15/2025, the order indicated 7/28/2025, RNA to perform PROM to BUE and BLE every day 5 times a week or as tolerated every dayshift. During a concurrent interview and record review on 8/14/2025 at 11:20 a.m., with Registered Nurse 2 (RN 2), Resident 90's Restorative Administration Record, 7/2025 and 8/2025 were reviewed. The record indicated Resident 90 did not receive RNA services five times a week or as tolerated for all RNA orders. RN 2 stated Resident 90 did not receive PROM for BLE and BUE five times a week as ordered. During an interview on 8/15/2025 at 4 p.m., with the Director of Nursing (DON), the DON stated that all residents should be provided with RNA services as ordered. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, revised 9/19/2019, the P&P indicated residents will receive RNA services as needed to help promote optimal safety and independence. RNA carries out the restorative program. d. During a review of Resident 54's admission record, the admission record indicated Resident 54 was initially admitted to the facility on [DATE] with diagnoses obstructive hydrocephalus (a blockage in the brain causing increased pressure in the skull), anoxic brain damage (the brain does not receive any oxygen resulting in brain cell death), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right elbow and hand. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 was severely cognitively (ability to learn, reason, remember, understand, and make decisions) impaired and was dependent (helper does all of the effort) for eating, toileting hygiene, bathing, and dressing. During a review of Resident 54's Physician Order Summary dated 8/15/2025, the Order Summary indicated the following orders: 1. RNA to apply a right elbow extension splint for up to four hours, five times a week 2. RNA to apply a Right Wrist-Hand-Finger Orthosis (WHFO-device that supports and immobilizes the wrist hand, and fingers to prevent joint stiffness) splint with hand grasp for up to four hours, five times a week 3. RNA to perform assisted active range of motion (AAROM- type of exercise where the resident moves a joint using their own muscles while receiving partial assistance) on bilateral lower extremities (legs), five times a week (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. RNA to perform passive range of motion (PROM- type of exercise where another person moves the resident's joint through its range of movement) to bilateral upper extremities (arms), five times a week 5. RNA to perform sit-to-stand exercises within the parallel bars, five times a week. During a concurrent interview and record review with Restorative Nurse Assistant (RNA) 3 on 8/14/2025 at 11:57 a.m., Resident 54's RNA flowsheets for July 2025 were reviewed. RNA 3 stated in July 2025, Resident 54 received the following: 1. Right elbow extension splint application on 18 out of 31 days. 2. Right WHFO splint application on 17 out of 31 days. 3. AAROM of the bilateral lower extremities on 18 out of 31 days. 4. PROM of the bilateral upper extremities on 18 out of 31 days. 5. Sit-to-stand exercises 16 out of 31 days. RNA 3 stated, if the order stated five times a week, Resident 54 should have received RNA services and splint application at least 20 times in one month. RNA 3 stated Resident 54 did not receive any of the ordered RNA services at least 20 times in July 2025. During an interview with the DON on 8/15/2025 at 4:10 PM, the DON stated it was important for residents to receive RNA services as ordered to prevent decline of range of motion and maintain mobility. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, revised 9/19/2019, the P&P indicated the program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The RNA documents the frequency of the program, the amount of time the resident spent in the activity and their tolerance to the program.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain acceptable nutritional parameters for one of three sampled residents (Resident 77) when:1. The facility failed to notify the physician on 7/29/2025 after Resident 77 had a significant weight loss (weight loss greater than 10 percent [%] in 6 months).2. The facility failed to ensure the Registered Dietician ([RD] a health professional who has special training in diet and nutrition) recommendations made on 7/29/2025 were implemented in a timely manner and not implemented on 8/4/2025, six days after the significant weight loss was identified. Resident 77's order for Ensure Enlive (nutritional supplement) three times a day was not ordered, and Resident 77 did not receive the supplement until 8/5/2025. Resident 77's order for Megestrol Acetate Suspension (appetite stimulant) was placed and carried out on 8/6/2025. 3. The facility failed to ensure Resident 77's amount eaten for every meal was recorded from 7/15/2025 to 8/12/2025, 29 out of 87 meals were not monitored and the amount eaten by Resident 77 was not recorded. These deficient practices had the potential to result in Resident 77 having severe weight loss of 12.28 % in six months (February to August). Findings:During a review of Resident 77's admission record, the admission Record indicated Resident 77 was admitted to the facility on [DATE] with a diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), acquired absence of stomach, tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] through the neck to allow for breathing) status, mild calorie protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and functions), diabetes mellitus (disorder where the body cannot regulate glucose or sugar like it should), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) affecting left non-dominant side.During a review of Resident 77's Minimum Data Set ([MDS] a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 77 had severe impairment in cognitive skills (thinking reasoning, remembering) for daily decision making. The MDS indicated Resident 77 was dependent (the helper does all the effort to complete the task) with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 77 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.During a concurrent interview and record review on 8/13/2025 at 9:52 a.m., with RD 1, Resident 77's Nutrition/ Dietary Note, dated 7/29/2025 at 8:40 p.m., was reviewed. The note indicated Resident 77's most recent weight was 149 lbs., a 3.8% weight change from 155 lbs., and Resident 77's goal weight was 160 lbs. to 170 lbs. RD 1 stated RD 2 recommended Ensure Enlive three times a day and for the physician to consider an appetite stimulant.During a concurrent interview and record review on 8/13/2025 at 9:55 a.m., with RD 1, Resident 77's Order Summary report, as of 8/13/2025, was reviewed. The report indicated on 8/5/2025, Enlive one carton three times a day with meals and on 8/6/2025, Megestrol Acetate Suspension 400 milligrams (mg)/ 10 ml, give 10 ml by mouth, one time a day, for appetite stimulant. RD 1 stated the RD recommendations were implemented one week after the identified weight loss. RD 1 stated recommendations should have been implemented sooner.During a concurrent interview and record review on 8/13/2025 at 12:29 p.m., with Registered Nurse (RN) 2, Resident 77's weight summary and medical records were reviewed. Resident 77's Weight Summary indicated Resident 77's weight on 2/4/2025, was 171 lbs., on 7/29/2025 Resident 77 weighed 149 lbs., on 8/4/2025 Resident 77 weighed 150 lbs. RN 2 stated that on 7/29/2025, Resident 77 had a 12.9% weight loss in approximately 6 months. RN 2 stated on 7/29/2025 the physician was not notified of the weight loss, no change of condition assessment was completed, and the RD recommendations to increase Enlive to three times a day and consider an appetite stimulant were not implemented. RN 2 stated RD 2's recommendations were implemented on 8/4/2025.During a concurrent interview and record review on (continued on next page)		

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

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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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Coral Cove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1730 Grand Ave Long Beach, CA 90804	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/13/2025 at 12:35 p.m., with RN 2, 77's Order Summary report, as of 8/13/2025 and Resident 77's Dietary - Amount Eaten, from 7/15/2025 to 8/12/2025, were reviewed. The order report indicated on 7/15/2025, there was an order for a Fortified diet (food with extra nutrients), mechanical soft texture (chopped, ground, or pureed foods), regular/thin consistency, no added salt, one to one feeding assistance with all meals and snacks, 16 ounces of fluids, meals, double protein with breakfast and lunch. Resident 77's, Amount eaten from 7/15/2025 to 8/12/2025 indicated 29 out of 87 meals were left blank, with no amount eaten documented, indicating meal intake was not monitored. RN 2 confirmed not all Resident 77's meals were monitored and documented, and Resident 77's intake could not be confirmed. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4 p.m., the DON stated the staff need to notify the physician for severe weight loss and the staff need to implement RD recommendations as soon as possible. During a review of the facility's policy and procedure titled Evaluation of Weight and Nutritional Status, revised 1/30/2025, the policy indicated: a) All residents will maintain acceptable parameters of nutritional status. b) The facility will implement interventions developed. c) The facility will monitor oral intake of foods and fluids and nutrition prescriptions. d) The physician will notify the physician of the weight variance of 10% in 6 months.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not provide respiratory care and services consistent with professional standards of practice to three of three residents (Resident 8, 63, and 82) when the facility failed to: a. Ensure Resident 8's oral hygiene and tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs) care was administered as ordered. b. Ensure Resident 63 received 2 liters of supplemental oxygen (element essential for life) as physician ordered. c. Ensure Resident 82's humidifier (medical device used to humidify supplemental oxygen) was labeled with a date to ensure it was changed timely. These deficient practices had the potential to result in a delay in care, infection and unsafe administration of oxygen in the facility. Findings: a. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and with diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), dependent on ventilator (a medical device to help support or replace breathing), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and a tracheostomy. During a review of Resident 8's Minimum Data Set ([MDS] a resident assessment tool), dated 8/6/2025, the MDS indicated Resident 8's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 8 was dependent (helper does all the effort to complete the task) on staff with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 8's Order summary as of 8/14/2025, the summary indicated the following: 1. Starting 4/3/2025, Tracheostomy care, every shift, clean with normal saline (solution to clean wounds), pat dry with gauze, and apply T-sponge (dressing that was precut offer snug fit around tracheostomies) and foam dressing if needed every shift. 2. Starting 7/31/2025, Chlorohexidine gluconate mouth and throat solution 0.12% (mouthwash to disinfect germs) give 15 milliliters (ml) by mouth every 12 hours for oral hygiene. During a concurrent interview and record review on 8/14/2025 at 10:27 a.m., with the Director of Respiratory services (DORT), Resident 8's Respiratory/Medication administration record (RMAR) for 8/2025 was reviewed. The RMAR indicated the prescribed Chlorohexidine oral hygiene was not administered as prescribed on 8/4/2025 and 8/10/2025 to 8/12/2025; and tracheostomy care was not administered as prescribed on 8/3/2025 and 8/10/2025. The DORT stated if it was not documented it was not completed. During an interview on 8/15/2025 at 4:00 p.m., with the Director of Nursing (DON) the DON stated oral hygiene and tracheostomy care should be administered as ordered. During a review of the facility's policy and procedure (P&P) titled, Tracheostomy Care, undated, the P&P indicated tracheostomy care will be provided every shift and as needed. During a review of the facility's P&P titled, Medication- Administration, revised 1/1/2012, the P&P (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated medications and treatments will be administered as prescribed. b. During an observation on 8/12/2025 at 9:32 a.m. in Resident 63's room. Resident 63 was observed receiving oxygen at 5L/min via NC. During a review of Resident 63's admission Record, the admission Record indicated the facility admitted Resident 63 on 6/29/2017, and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breath), and cognitive communication deficit (when someone has trouble understanding and using language because of problems with their thinking skills, like attention, memory, and problem-solving). During a review of Resident 63's History and Physical (H&P), dated 6/3/2025, the H&P indicated, Resident 63 could make needs known but could not make medical decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident63 was dependent (helper does all of the effort) with showering, upper body dressing, lower body dressing, putting on/ taking off footwear, required maximal assistance (helper does more than half the effort to complete task) toileting hygiene, required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with oral hygiene, set up or clean up assistance with eating and personal hygiene. During a review of Resident 63's Order Summary Report, dated 8/12/2025, the Order Summary Report indicated that starting 6/9/2023, to administer oxygen at 2 liters per minute (L/min-a unit of oxygen flow rate) via (through) nasal cannula continuously to keep oxygen saturation at and above 90% for shortness of breath/COPD. During a concurrent interview and record review on 8/12/2025 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 63's Order Summary Report, orders of 8/12/2025 were reviewed. LVN 1 stated the Order Summary Report indicated Resident 63 should receive 2L/min via NC. During a concurrent interview and observation on 8/12/2025 at 9:46 a.m. with LVN 1, LVN 1 stated Resident 63 was receiving oxygen at 5 L/min via NC, it was too much oxygen than ordered, and this could be unsafe and harmful to him. During an interview on 8/14/2025 at 3:04 p.m. with the Director of Nursing, the DON stated oxygen is considered a medication, and staff should follow physician's order and ensure that oxygen is administered properly. c. During a review of Resident 82's admission Record, the admission Record indicated the facility admitted Resident 82 on 8/9/2021, and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breath), emphysema (a chronic lung condition where the air sacs in the lungs are damaged and enlarged, making difficult to breathe), chronic pulmonary edema (a long-term condition where fluid builds up in the lungs making it hard to breathe) and pneumonia (along infection that causes the air sacs in one or both lungs to become inflamed and fill with fluid or pus). During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82's cognitive (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(functions your brain uses to think, pay attention, process information, and remember things) was intact. The MDS indicated Resident 82 required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, upper body dressing, lower body dressing, personal hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene and showering. During a review of Resident 82's Order Summary Report, orders as of 8/12/2025, the Order Summary Report indicated an order, starting 6/15/2025, to change the humidifier every Sunday, night shift. During a review of Resident 82's care plan for oxygen therapy titled Ineffective gas exchange, respiratory illness, revised 4/3/2025, the care plan's interventions indicated staff need to change humidifier weekly or as needed. During a concurrent observation and interview on 8/12/2025 at 8:37 a.m. with Certified Nurse Assistant (CNA) 2 in Resident 82's room, Resident 82's humidifier was observed without date marked on the humidifier bottle or the humidifier tubing. CNA 2 stated she did not see any mark on the humidifier. During an interview on 8/14/2025 at 3:04 p.m. with the Director of Nursing, the DON stated staff are required to date the humidifier upon application and change it weekly, or as needed, to ensure infection control. During a review of the facility's policy and procedure (P&P) titled, Oxygen therapy, revised 11/2017, the P&P indicated staff must administer oxygen per physician orders and the humidifier and tubing should be changed no more than every 7 days and labeled with the date of change.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to: 1.Ensure food is properly stored with label and open date. 2.Ensure expired food is discarded. 3.Monitor the temperature of the hydration freezer. These failures had the potential to expose all residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another) which could lead to nausea, vomiting or diarrhea. Findings: During a concurrent observation and interview with the Dietary supervisor (DS) in the kitchen on 8/12/2025 at 8:14 a.m., the following were observed: a. Two Italian dressings with a use by date of 6/30/2025 in the dry storage.b. One container of chili oil with a use by date of 8/8/2025 in the refrigerator.c. One shelf of unlabeled popsicles in individual clear packaging and two shelves of unlabeled popsicles in opaque packaging without expiration dates in the hydration freezer. The DS stated the hydration freezer does not have a thermometer to monitor temperatures and was not monitored with a thermometer or temperature log. The DS stated because the popsicles are out of their original packaging, we do not know what flavors the popsicles are, the ingredients, or when they expire. The DS stated it is important to properly store food with labels and open dates, dispose of food by the use by dates, and to monitor the temperature of refrigerators and freezers to prevent food borne illnesses. During a concurrent observation and interview with the DS in the activity room on 8/14/2025 at 10:55 a.m., the resident refrigerator and freezer were inspected. The following was observed: a. One box of chicken wings in a to-go container was not labeled with a date in the refrigerator. b. Two ice cream sandwiches were coming out of the paper packaging in the freezer.The DS stated not having labels and properly stored food will place the residents at risk for cross contamination and food borne illness. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4:10 p.m., the DON stated if food is not properly stored, monitored, or discarded, there is a risk of the infection control and discomfort for the residents. During a review of the facility's policy and procedure (P&P), titled Food Storage and handling, revised 2/29/2024, the P&P indicated: 1. Frozen foods should be labeled, dated, and in their original containers if designed for freezing. Foods to be frozen should be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated paper. 2. Label and date all storage products in the Dry Storage area. During a review of the facility's policy and procedure (P&P), titled Refrigerator/Freezer Temperature Records, revised 11/1/2024, the P&P indicated a daily temperature record is to be kept for refrigerated and frozen storage areas.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: a) Ensure to offer the Corona virus disease ([COVID-19] contagious infectious disease) vaccination (medications used to prevent diseases usually given by injection or by mouth) to one of five sampled residents (Resident 95). b) Ensure to provide documented evidence of all employees, including consultants and physicians, COVID-19 vaccination status and the provision of education on benefits and potential side effects and offering of the 2024 to 2025 COVID-19 vaccine. This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death. Findings: During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses including a history of COVID-19 and cerebral infarction (stroke - loss of blood flow to a part of the brain). During a review of Resident 95's Minimum Data Set ([MDS] a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 95's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 95 needed set-up assistance with eating, oral and personal hygiene, needed substantial assistance (helper does more than half the effort to complete the task) with showering. During a concurrent interview and record review on 8/13/2025 at 4:10 p.m., with the Infection Prevention Nurse (IPN), Resident 95's medical records were reviewed. The IPN stated there was no documented evidence Resident 95 was offered, educated on benefits and risks of the 2024 to 2025 COVID-19 vaccine. During an interview and record review on 8/14/2025 at 10:06 a.m., with the IPN, the facility's Covid Staff Vaccination Status for Providers, prepared 8/1/2025, was reviewed. The IPN stated there was no documented evidence for all staff of education on benefits and side effects was provided and the offering of 2024 to 2025 Covid-19 booster vaccine. The IPN stated the roster also did not include physicians or consultants and it should include everyone that has direct access to the residents. During an interview on 8/15/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated staff and residents need to be educated and offered the 2024-2025 COVID-19 booster. The DON stated the facility needs employees Covid Vaccination status updated including physicians and consultants. During a review of the facility's policy and procedure (P&P) titled, Management of Covid-19, revised 10/11/2022, the P&P indicated the following: a. Employees are required to have a COVID-19 booster dose when eligible for employment unless there is an approved religious or medical waiver. b. Residents are encouraged to receive COVID-19 vaccination and boosters. c. The facility will maintain documentation of resident and staff vaccination status. d. Vaccines will be provided to residents and staff.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of Resident 62s Electroencephalogram ([EEG] - is a test that measures the electrical activity in the brain, called brain waves, using small metal disks called electrodes that are attached to the scalp) test was incomplete. This deficient practice had the potential for Resident 62 to have a delayed diagnosis and treatment of neurological conditions placing Resident 62 at risk for worsening symptoms. Findings: During a review of Resident 62's admission Record (Face Sheet), the admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses anoxic brain damage (a complete lack of oxygen to the brain, leading to cell death and lasting harm, even if it's only for a few minutes) and dementia (a progressive state of decline in mental abilities). During a review of Resident 62's minimum data set (MDS: a resident assessment tool), dated 6/25/2025, the MDS indicated Resident 62 was cognitively (mental action or process of acquiring knowledge and understanding ability) severely impaired. During a concurrent interview and record review on 08/14/2025 at 3:49 pm with LVN 4, LVN 4 Stated EEG was ordered due to Resident 62 having dementia, and as elderly. LVN 4 stated that any nurse can follow orders through the facility's twenty-four-hour Communication in the PCC (Point Click Care) system to ensure no orders will be missed. LVN 4 stated it was important to communicate to prevent complications. LVN 4 confirmed EEG order, but no staff followed through for EEG . LVN stated when Medical Doctor (MD) made rounds she was the one in charge and EEG was ordered on 5/9/2025. During a review of the neurology note titled Neurology dated 5/9/2025, indicated that MD ordered EEG for Resident 62' subclinical seizure activities. During a record review of the Policy and Procedure titled Referrals to outside services dated 12/2013, the P and P indicated the facility provide residents with outside services as required by physician orders or the care plan.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer and Discharge Form (written notification to the resident or responsible party that included the reason for the transfer or discharge, where the resident will be transferred or discharged to, how to contact the State Long Term Care Ombudsman, and how to appeal the transfer or discharge if necessary) was provided timely to the resident's responsible party (RP) 1 for one of two residents (Resident 90). This deficient practice had the potential to result in the RP 1's ability to contact the State Long Term Care Ombudsman (public advocate) on how to appeal the transfer if needed. Findings: During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was originally admitted to the facility on [DATE] with diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), dependent on a ventilator (a medical device to help support or replace breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) affecting left non-dominant side. During a review of Resident 90's Minimum Data Set ([MDS] a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 90's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 90 was dependent on staff with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 90's Change of Condition Evaluation, dated 6/7/2025 at 7:07 a.m., the evaluation indicated at approximately 6:44 a.m. Resident 90 was observed in severe respiratory distress and at 6:47 a.m. Emergency Medical Services were called. The evaluation indicated at 7:08 a.m. Resident 90 was transferred to a general acute care hospital (GACH 1) for evaluation. During a concurrent interview and record review on 8/13/2025 at 3:39 p.m., with Registered Nurse (RN) 2, Resident 90's clinical records were reviewed, and RN 2 stated Resident 90 had a change of condition and was transferred to GACH 1 on 6/7/2025. RN 2 stated the Notice of Proposed Transfer and Discharge Form was not completed and given to the responsible party or the ombudsman. During an interview on 8/15/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated transferred residents need the written Notice of Proposed Transfer and Discharge Form to be faxed to the ombudsman. During a review the facility's policies and procedure (P&P) titled, Transfer and Discharge of Residents, the P&P indicated the following: 1. A copy of the Notice of Proposed Transfer and Discharge will be placed in the Resident's medical Record and a copy faxed to the ombudsman. 2. Within 48 hours of giving the written notice of the facility-initiated transfer or discharge, the facility shall provide the resident and, if applicable, the resident representative a copy of both the following: a. The evaluation of the residents' discharge needs and discharge plan as required by federal law and regulations or the most current discharge care plan. b. In the case of the transfer being necessary for the resident's welfare because the resident's needs cannot be met in the facility, the following information should be included: i. A written description of the specific Resident's needs that cannot be met; ii. Facility attempts to meet the Resident's needs; and iii. The services available at the receiving facility that meet the resident's needs.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document Restorative Nurse Assistant (RNA- a Certified Nurse Assistant (CNA) who received special training to provide range of motion (ROM) and daily activities under the guidance of nurses and therapists) services on the Minimum data set (MDS - a resident assessment tool), for one of three sampled residents (Resident 54). This failure had the potential to result in Resident 54 to have a delay of care. Findings: During a review of Resident 54's admission record, the admission record indicated Resident 54 was initially admitted to the facility on [DATE] with diagnoses including obstructive hydrocephalus (a blockage in the brain causing increased pressure in the skull), anoxic brain damage (the brain does not receive any oxygen resulting in brain cell death), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right elbow and hand. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 7/17/2025, the MDS indicated Resident 54 had severe cognition (ability to learn, reason, remember, understand, and make decisions) and was dependent (helper does all of the effort) for eating, toileting hygiene, bathing, and dressing. During a review of Resident 54's Physician Order Summary dated 8/15/2025, the Order Summary indicated the following orders:RNA to apply a right elbow extension splint for up to four hours, five times a week RNA to apply a Right Wrist-Hand-Finger Orthosis (WHFO-device that supports and immobilizes the wrist hand, and fingers to prevent joint stiffness) splint with hand grasp for up to four hours, five times a week During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 8/15/2025 at 12:27 p.m., Resident 54's RNA flowsheet for July 2025 and MDS dated [DATE] were reviewed. The MDSC stated the MDS reflects how many days a resident received a type of RNA services (such as splint application) if the service provided was at least 15 minutes during a specific date range or look back period. The MDSC stated Resident 54 received RNA services of splint application on 7/12/2025 and 7/14/2025 greater than 15 minutes during the look back period of 7/11/2025 - 7/17/2025.The MDSC stated Resident 54's MDS dated [DATE] indicates Resident 54 did not receive RNA services of splint application of at least 15 minutes from the dates of 7/11/2025-7/17/2025. The MDSC stated the MDS is inaccurate and should reflect that resident 54 received two days of splint application. The MDSC stated if the MDS does not accurately reflect the resident, there is a risk that the resident will not receive proper care. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4:00 PM, the DON stated it is important for the MDS to reflect the whole care of the resident. The DON stated if the MDS is inaccurate, it can lead to a possible delay of care. During a review of the facility's policy and procedure (P&P), titled RAI Process, revised 10/4/2016, the P&P indicated the facility will utilize the Resident Assessment instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status. During a review of the facility's policy and procedure (P&P), titled Completion & Correction, revised 1/1/2012, the P&P indicated that medical records are complete and accurate and documentation will reflect medically relevant information concerning the resident.		

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NAME OF PROVIDER OR SUPPLIER Coral Cove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1730 Grand Ave Long Beach, CA 90804	
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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** Based on interview and record review the facility failed update the care plan titled, Nutrition after significant weight loss (weight loss greater than 10% in 6 months) was identified on 7/29/2025 for one of three sampled residents (Resident 77).These deficient practices resulted in a delay in care and services to improve weight loss.Findings:During a review of Resident 77's admission record, the admission Record indicated Resident 77 was admitted to the facility on [DATE] with a diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), acquired absence of stomach, tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] through the neck to allow for breathing) status, mild calorie protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and functions), diabetes mellitus (disorder where the body cannot regulate glucose or sugar like it should), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) affecting left non-dominant side.During a review of Resident 77's Minimum Data Set ([MDS] a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 77 had severe impairment in cognitive skills (thinking reasoning, remembering) for daily decision making. The MDS indicated Resident 77 was dependent (the helper does all the effort to complete the task) with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 8/13/2025 at 9:52 a.m., with the Registered Dietician ([RD] nutrition expert) 1, Resident 77's Nutrition/ Dietary Note, dated 7/29/2025 at 8:40 p.m., was reviewed. The RD stated the note indicated Resident 77's most recent weight was 149 lbs., a 3.8% weight change from 155 lbs., and Resident 77's goal weight was 160 lbs. to 170 lbs. RD 1 stated RD 2 recommended Ensure Enlive (nutritional supplement) three times a day and for the physician to consider an appetite stimulant. During a interview and record review with RN 2 on 8/13/2025 at 12:59 a.m., Resident 77's Care plan report, initiated on 7/3/2025, was reviewed. The care plan indicated Resident 77 had a 4 lbs. weight loss in one month (7.5 % in 90 days). RN 2 stated Resident 77's care plan was not updated with RD new recommendations on 7/29/2025.During an interview with the Director of Nursing (DON) on 8/15/2025 at 4 p.m., the DON stated the staff should update the care plan if there are changes. During a review of the facility's policy and procedure titled Evaluation of Weight and Nutritional Status, revised 1/30/2025, the policy indicated the Interdisciplinary Team will update and revise the care plan as appropriate.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 7) received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial needs by: Failing to follow up with a referral consultation for rheumatology (medical specialty focused on the diagnosis and treatment of disorders affecting connective tissues like bones, muscles, joints, and tendons [tissue connecting muscle to bone]) and neurology (medical specialty focused on diagnosis and treatment of disorders of the brain, spinal cord, and nerves), and a follow-up appointment in six weeks on 10/1/2024 for results. This deficient practice resulted in Resident 7 not being seen by a Rheumatologist since 10/1/2024, and was not informed about his X-ray (type of radiation that creates pictures of the inside of your body) results that was done in 5/22/2025. Findings: During a review of Resident 7s admission Record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), rotator cuff (group of muscles and tendons that surround the shoulder joint) tear or rupture of right shoulder, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left knee, right and left hand, and left elbow. During a review of Resident 7's initial evaluation from the Orthopedic Surgery Specialists ([NAME]: medical specialty focused on conditions and injuries of the bones, joints, muscles, ligaments, and tendons) dated 10/1/2024, the [NAME] evaluation indicated the following recommendations: 1. Magnetic Resonance Imaging (MRI: diagnostic test that creates detailed pictures of the inside of the body such as the brain, spinal cord, and joints), 2. Referral to neurology, 3. Referral to rheumatology, and 4. A follow up appointment in 6 weeks for review of the MRI results. During a review of Resident 7's order summary, the order summary indicated there was an order for Resident 7 to see a Rheumatology specialist and get an MRI for right shoulder pain on 10/3/2024 and was discontinued on 12/8/2024. During a review of Resident 7's MRI results of the right shoulder dated 12/16/2024, the MRI of the right shoulder indicated the rotator cuff tendon (group of tough connective tissues that attach the four rotator cuff muscles to the top of the upper arm bone) was thinning, suggesting chronic (progressive) tendinosis (condition where a tendon has degenerated due to overuse or repetitive stress, leading to pain and stiffness) and the rotator cuff muscle (group of muscles and tendons that surrounds your shoulder) show deterioration. During a review of Resident 7's history and physical (H&P) dated 1/20/2025, the H&P indicated Resident 7 has the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set ([MDS] a resident assessment tool) dated 5/20/2025, the MDS indicated Resident 7's cognition (ability to think and reason) was intact. The MDS indicated Resident 7 was dependent on staff for all aspects of activities of daily living (ADLs: activities such as bathing, dressing, personal/oral hygiene, and toileting). The MDS indicated Resident 7 had impairments on both the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 7's Radiology (medical specialty that uses imaging technologies X-rays to diagnose and treat diseases) Results Report dated 5/22/2025 at 6:07p.m., the radiology results report indicated the shoulder complete minimum 2 view (v) (complete shoulder X-ray examination that requires two views from different angles to diagnosis fractures or arthritis) indicated the left and right shoulder have mild degenerative joint diseases. During a review Resident 7's Transportation Request Form dated 8/8/2025, the transportation request form indicated a request for transportation to a neurology appointment for Resident 7 on 8/12/2025 at 9:30a.m. During an interview on 8/12/2025 at 10:20 a.m., Resident 7 stated an MRI of the right shoulder was done in December 2024, but the results did not come back until January 2025. Resident 7 stated he was still waiting for his rheumatology consult. During a concurrent interview and record review on 8/12/2025 at 11:29 a.m., with Registered Nurse 4 (RN) 4, Resident 7's medical records were reviewed. RN 4 stated (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if there was an order for a consultation, the Case Manager (CM) arranges for authorization and nurses make the appointments. RN 4 stated the orthopedic consultation done on 10/1/2024 was reviewed by the nurses and sent to the primary physician. RN 4 stated if they saw the consultation requests, they would notify the doctor of the recommendations, write the order, and give it to the CM for authorization. RN 4 stated there was an MRI of the right shoulder done on 12/16/2024. RN 4 stated Resident 4 returned from the hospital on 1/20/2025. RN 4 stated she does not see an order for the orthopedic after January 2025 and indicated Resident 7 should have had an orthopedic consultation done after the MRI was completed. RN 4 stated there was a referral for rheumatology and neurology on 10/3/2024 however there was no follow up done. RN 4 stated Resident 7's neurology and rheumatology appointments were not followed up with. RN 4 stated physician's and medical specialty appointments are important as there is a reason for the order and if Resident 7 does not get assessed, it can cause more pain and have a negative effect. During an interview on 8/12/2025 at 1:39 p.m., with Resident 7, Resident 7 stated on 8/11/2025 he received his MRI results and was informed on 8/11/2025 he had a neurology appointment on 8/12/2025. Resident 7 stated, back in 2024, the orthopedic surgeon wanted him to see the neurologist and the rheumatologist. Resident 7 stated he needed to see the rheumatologist, but instead he was sent to a neurologist and was confused as he did not need to be sent out to see a neurologist, he had already seen one. Resident 7 stated he may have rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility) and needs to find a way to get a rheumatology appointment as his arm has gotten worse with constant pain in the shoulders. Resident 7 stated he does not want to take pain medications and the nurses are putting on a lidocaine patch (topical patch used for neuropathic pain by blocking pain signals from damaged nerve) to treat his pain. Resident 7 stated he is able to move from his elbow to hand, but if he tries to move further, there is a lot of pain and indicated the MRI result showed his bone is deteriorating. Resident 7 stated since 12/2024, the facility has not done anything and now needs to see a rheumatologist. During an interview on 8/14/2025 at 3:57 p.m. with Resident 7, Resident 7 stated on the morning of 8/14/2025, a Nurse Practitioner U (NP U) to inform him according to the x-ray results both his shoulders indicated bone degeneration. During a concurrent interview and record review on 8/15/2025 at 1:14p.m. with RN 4, RN 4 stated the nurses notify the doctor, family, and residents regarding results that are available from the procedures done. RN 4 stated the X-ray results done on 5/22/2025 was relayed to the doctor on 5/23/2025 with no new orders. RN 4 stated it is important for the residents to be informed of their medical test results as it is their right to know. During an interview on 8/15/2025 at 1:41p.m., with the Director of Nursing (DON), the DON stated if there is a referral, the nurses receive it and notify the doctor about the referral. The DON stated if a procedure was done, the nurses would check for results and notify the doctor of the results. The DON stated if a resident is alert, the results would be notified to them and/or the family representative would be informed. The DON stated the nurses would explain the results to the residents. The DON stated referrals are important as there is a reason as to why the resident was referred, and not going to their referrals could potentially make the resident have continued discomfort. The DON stated it was important for referrals to be followed up with. The DON stated the best practice is to alert residents about their results to and answer any questions they may have so they don't continue to worry not knowing what is going on. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 1/1/2012, the P&P indicated the purpose is to promote and protect the rights of all residents at the facility. During a review of the facility's P&P titled, RN Supervisor Job Description, undated, the P&P indicated the RN Supervisor is to assist the planning, organizing, developing and directing of nursing services to assure that the highest degree of quality of resident care can be maintained at all times. Assist the Charge Nurse and other nursing personnel in performing nursing procedures as necessary. Assure that all nurse's notes are charted in an informative and descriptive manner that reflects the care provided as well as the resident's response to the care. During a review of the facility's P&P titled, Resident Rights-Quality of (continued on next page)		

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Life revised 3/2017, the P&P indicated to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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 suppose the resident in attaining or maintaining his/her highest practicable well-being. Facility staff keeps the resident informed and oriented to his/her environment. Procedures are explained to the residents before they are performed and the resident is told in advance if he/she is to be taken out of his/her usual or familiar surroundings. During a review of the facility's P&P titled, Referrals to Outside Services revised 12/1/2013, the P&P indicated the purpose is to provide residents with outside services as required by physician orders or the Care Plan. The Director of Social Services coordinate the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the facility. Referrals for medical services are only made pursuant to an Attending Physician's order. The Director of Social Services will coordinate with Nursing Staff to ensure that the Attending Physician's order and referral to outside provider is documented in the resident's medical record. During a review of the facility's P&P titled, Physician Orders effective date 12/28/2022, the P&P indicated documentation pertaining to physician orders will be maintained in the Resident's medical record.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of three sampled dependent resident's (Resident 90) toenails were not dirty and thick. This deficient practice had the potential to result in infection, a decreased quality of life and negatively impact the residents' self-esteem. Findings: During a concurrent observation and interview on 8/12/2025 at 9:45 a.m. in Resident 90's room, with Registered Nurse (RN)1, Resident 90 was noted with dirty, discolored and thickened toenails. RN 1 stated the Resident 90's toenails were dirty and thickened and the treatment nurse should be looking at it and the wound doctor should be following it up. During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was originally admitted to the facility on [DATE] with diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dependent on a ventilator (a medical device to help support or replace breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) affecting left non-dominant side. During a review of Resident 90's Minimum Data Set ([MDS] a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 90's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 90 was dependent on staff with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 90's Order, starting 7/26/2025, the order indicated Podiatry Services as indicated. During an interview and record review on 8/13/2025 at 3:13 p.m., with RN 3, Resident 90's medical records were reviewed, RN 3 stated the records did not have documented evidence of Resident 90 being seen or referred to the podiatrist recently. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4:00 p.m., the DON stated grooming was an important aspect of resident care and toenails need to be clean. The DON stated Resident 90 was last seen by the podiatrist in 2/2025. During a record review of the facility's policy and procedure (P&P) titled, Grooming, revised 1/1/2012, the P&P indicated the facility will work with residents to promote hygiene and dignity through grooming. The P&P indicated residents who have medical conditions such as diabetes may only have their toenails clipped by a licensed nurse.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 14 sampled residents (Resident 98 and Resident 101) who are fed by a gastrostomy tube (GT - a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) were following appropriate standard of practice by: a. Failing to ensure the tube feeding was disconnected from Resident 98 when the feeding was turned off. b. Failing to follow the care plan and hold the tube feeding while Resident 101 was lying flat. This deficient practice had the potential to cause dislodgement for Resident 98 and result in aspiration (inhalation of foreign materials) which can lead to pneumonia (a lung infection) for Resident 101. Findings: a. During a review of Resident 98's admission Record (Face Sheet), the admission Record indicated Resident 98 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including gastrostomy tube (GT &ndash; a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 98's Minimum Data Set ([MDS] a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 98 was cognitively severely impaired. The MDS indicated Resident 98 is dependent on all aspects of activities of daily living (ADL: bathing, oral/toileting/personal hygiene, roll left and right). Resident 98 has an impairment on one side of the upper (arm/shoulder) extremity and impairment on both sides of the lower (hips/legs) extremities. During a concurrent observation and interview on 8/12/2025 at 9:45a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 98's feeding is turned off at 8:00a.m. and is restarted at 12:00p.m. and is on for 20 hours (hrs.). LVN 2 stated the tube feeding is connected to Resident 98, however the feeding is turned off and indicated leaving the tube feeding connected to the resident after the feeding is turned off is standard of practice. LVN 2 stated the tube feeding will be disconnected if the Certified Nursing Assistants (CNA) takes the resident for a shower or to the dining room, but the feeding tube is normally attached to the resident when they are in bed and does not disconnect it. LVN 2 stated leaving the tube feeding connected can possibly lead to dislodgement and entanglement. During an interview on 8/15/2025 at 1:42p.m. with the Director of Nursing (DON), the DON stated ideally, after a tube feeding is completed, you would want to detach it from the resident to ensure the residents can be free as they may need to be repositioned or require ADL, and keeping the tube feeding attached can lead to discomfort and possible dislodgement. b. During a review of Resident 101's admission Record (Face Sheet), the admission Record indicated Resident 101 was initially admitted to the facility 4/7/2020 and was readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infection (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left dominant side, gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and Type II Diabetes Mellitus (DM: a chronic disease that affects how the body processes sugar). (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 101's H&P dated 12/22/2024, the H&P indicated Resident 101 does not have the capacity to understand and make decisions. During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 101's cognition was severely impaired. The MDS indicated Resident 101 is dependent on all aspects of performing activities of daily living (ADLs: activities such as bathing, dressing, personal/oral hygiene, and toileting). The MDS indicated Resident 101 has impairment on both sides of the upper and lower extremity. During a review of Resident 101's Order Summary Report, orders of 8/12/2025, the Order Summary Report indicated the following physician orders: - Starting 4/29/2025, elevate head of bed 30-45 degrees during feedings, every shift. - Starting 3/28/2025, feed Jevity 1.5 (concentrated, all-in-one nutritional drink designed to help people gain or maintain a healthy weight) at 50 milliliters/hour (mL/hr.-how many milliliters of a liquid are delivered or flow in one hour) for 20 hours through enteral pump (a medical device that helps deliver liquid nutrition directly into a person's stomach or small intestine through a feeding tube) to provide 1000 milliliters/1500 kilocalorie (the scientific term for the energy in food) a day, start feeding at 12 p.m. and off at 8 a.m. or until dose is met. During a review of Resident 101's Care Plan Report for a swallowing problem, revised 4/10/2025, the Care Plan Report indicated Resident 101 required enteral nutrition through a gastrostomy tube. The Care Plan's goal indicated Resident 101 would not have injury related to aspiration and have clear lungs, no signs or symptoms of aspiration. The Care Plan's interventions included keeping her head of bed elevated 30-45 degrees, and monitoring for choking, shortness of breath, labored respirations, lung congestion. During a concurrent observation and interview on 08/12/2025 at 2:34 p.m. with LVN 4 and CNA 3 in Resident 101's room, Resident 101's tube feeding was observed. The tube feeding was running at 50 mL/hr. and Resident 101 was lying flat on her left side. LVN 4 was provided treatment on her bottom while CNA 3 was holding her, they placed her back on her back after the treatment. LVN 4 stated the tube feeding was running during the treatment when she was lying flat, but it should be turned off prior to the treatment to prevent aspiration. During an interview on 8/14/2025 at 3:04 p.m. with the Director of Nursing (DON), the DON stated staff need to hold tube feeding during the treatment to prevent aspiration or any discomfort to the residents. During an interview on 08/15/2025 at 3:43 p.m. with the DON, the DON stated that even though there are no specific policy guidelines regarding holding tube feeding while residents are flat, it is required based on nursing judgement and professional standards of care. During a review of the facility policy and procedure (P&P) titled Feeding Tube-Administration of Medication dated 6/12/2024, the P&P indicated to elevate the head of the bed at least 30 degrees.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who received dialysis (process of removing waste products and excess fluid from the body) received treatment as ordered for one out of one sampled resident (Resident 10). This deficient practice had the potential to delay provision of dialysis treatment. Findings:During a review of Resident 10's admission Record (Face Sheet), the admission Record indicated Resident 10 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including dialysis, Type 2 (II) Diabetes Mellitus (DM: a chronic disease that affects how the body processes sugar), and congestive heart failure (CHF: a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 10's history and physical (H&P) dated [DATE], the H&P indicated Resident 10 has the capacity to understand and make decisions.During a review of Resident 10's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 10 was cognitively (ability to think and reason) intact. The MDS indicated Resident 10 required maximal assistance (provides more than half the effort) from sit to stand, chair/bed-to-chair, required moderate assistance (provides less than half the effort) for toileting hygiene, bathing, dressing upper (above waist) and lower (below waist) dressing, putting on shoes, and required set up for oral hygiene and eating. During a review of Resident 10's pre and post dialysis document, the pre and post dialysis document indicated the last day Resident 10 had dialysis was on [DATE] and the next dialysis treatment was received on [DATE]. During a review of Resident 10's Change of Condition (COC: deviating from what is normal), dated [DATE] at 10:12a.m., the COC indicated Resident 10 had missed his dialysis appointment on [DATE]. The COC indicated the recommendation was to call the dialysis center and reschedule a makeup dialysis. During a concurrent interview and record review on [DATE] at 6:32a.m. with Registered Nurse 5 (RN 5), RN 5 indicated on [DATE], Resident 10 was waiting for transportation to be taken to dialysis, but the transportation never came and was informed by transportation Resident 10's eligibility to be transported expired and Resident 10 would need to reapply. RN 5 stated the dialysis center informed him Resident 10 could reschedule his dialysis the same day on [DATE] or the following day on [DATE]. RN 5 stated there was an oindications2/2025 for Resident 10 to receive dialysis on [DATE] at 12:00 p.m. RN 5 stated there were no indication on the progress notes or the pre and post dialysis documentation Resident 10 received dialysis on [DATE]. RN 5 stated if a resident missed dialysis, there is a risk for fluid overload, edema (build-up of fluid in the body's tissue), worsening of kidney failure, risk for altered mental status (AMS), and abnormal labs. RN 5 stated the facility offers transportation and will call for private transportation when needed. During an interview on [DATE] at 10:46a.m. with the Social Service Director (SSD), the SSD stated if there was an order on [DATE] for Resident 10 to go to dialysis, they would have arranged a private transportation for the resident to go to dialysis. During an interview on [DATE] at 1:44p.m. with the Director of Nursing (DON), the DON stated if there was missed transportation, the facility can provide transportation. The DON stated Resident 10 could have gone to dialysis on [DATE]. The DON stated there would be documentation that Resident 10 had received dialysis on [DATE], but the charting is incomplete and does not have any documentation. The DON stated the potential for missing dialysis for a day could lead to discomfort, blood pressure (force of blood pushing against the walls of your blood vessels in the heart) might elevate, and cause fluid overload.During a review of the facility's policy and procedure (P&P) titled, Dialysis Management effective date [DATE], the P&P indicated the facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice. The P&P indicated the facility will arrange transportation to and from the dialysis provider. The P&P indicated all documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a Licensed Vocational Nurse (LVN 3) remained competent in medication administration for one of one residents (Resident 119) by not re-evaluating LVN 3's competency skills when Resident 119 expressed concerns of receiving more pills than her usual medication pass. This failure had the potential to lead to medication errors for Resident 119 and all residents. Findings: During a review of Resident 119's admission Record, the admission Record indicated the facility admitted Resident 119 on 9/6/2022, readmitted on [DATE] and discharged on 5/1/2025. The admission record indicated Resident 119 had diagnoses including hypertension (high blood pressure) and neuropathy (nerve pain). During a review of Resident 119's History and Physical (H&P), dated 4/1/2025, indicated, Resident 119 had the capacity to make a decision. During a review of Resident 119's Minimum Data Set (MDS- a resident assessment tool), dated 5/1/2025, indicated Resident 119's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was intact. The MDS indicated Resident 119 required moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene, showering, set-up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, and personal hygiene. During a review of Resident 119's Order Summary Report, dated 8/9/2024 to 12/1/2024, the Order Summary Report indicated an order starting 8/9/2024, to administer Gabapentin (a medication primarily used to manage seizures and nerve pain) capsule 300 milligrams (mg- unit of measurement) by mouth every six hours for neuropathy, four times a day for a total 1200mg daily. The Order Summary Report indicated the same order starting 12/1/2024, to administer Gabapentin capsule 300mg by mouth every six hours for neuropathy, for total of 1200mg daily. During a review of Resident 119's Medication Admin Audit Report, dated 11/12/2024, the Medication Admin Audit Report indicated Gabapentin order for the date was to administer 300mg by mouth every six hours for neuropathy, four times a day, for total of 1200mg daily. The Admin Audit Report indicated the administration was scheduled for 11/12/2024 at 00:00. The Actual administration time was recorded as 11/12/2025 at 00:41 a.m., and LVN 3's documentation time was 11/12/2024 at 00:41 a.m. During a telephone interview on 8/15/2025 at 1:06 p.m. with LVN 3, LVN 3 stated he did not recall the date but remembered he helped the resident with gabapentin medications, he brought 4 tabs of gabapentin 300mg, altogether 1200mg to Resident 119, she told him that was not her usual, and she took one instead of four, which was 300mg. LVN 3 stated the order was confusing to him, and did not clarify the order because he was the only one working, no one was available to help him. During a concurrent interview and record review on 08/15/2025 1:46 p.m. with Registered Nurse (RN) 4, LVN 3's employee file, undated, was reviewed. RN 4 stated there was no documentation regarding the incident including incident report, related in-service record, or skills re-evaluation in his employee file. RN 4 stated LVN 3 should have called the physician to clarify medication order when the order was confusing and Resident 119 expressed concerns. RN 4 stated it could have led to a medication error that affected the residents negatively. RN 4 stated the facility should have provided an in-service to him related to the incident, did a skills re-evaluation, and took disciplinary action if necessary to prevent a similar incident. RN 4 stated she could not tell if LVN 3 was competent to pass medications. During an interview on 8/15/2025 at 3:43 p.m. with the Director of Nursing (DON), the DON stated the facility should maintain staff competency with skill evaluation, competency validations, providing in-service, or disciplinary actions when concerns rise beside the initial orientation to prevent similar incidents happening again. During a review of facility's policy and procedure (P&P) titled, Staff Competency Validation, revised 3/28/2024, the P&P indicated re-education will be provided to the employee who is unable to satisfactorily perform the skill, followed by a re-evaluation of the competency, the competency validation is retained in the employee file.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered on time for one of four sampled residents (Resident 7). This failure had the potential to result in Resident 7's pain not being managed or experiencing adverse medication side effects. Findings: During a review of Resident 7s admission Record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), rotator cuff (group of muscles and tendons that surround the shoulder joint) tear or rupture of right shoulder, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left knee, right and left hand, and left elbow. During a review of Resident 7's history and physical (H&P) dated 1/20/2025, the H&P indicated Resident 7 has the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool) dated 5/20/2025, the MDS indicated Resident 7's cognition (ability to think and reason) was intact. The MDS indicated Resident 7 was dependent on eating, toileting, bathing, and dressing. During a review of Resident 7's Physician Order Summary 8/15/2025, the Order Summary indicated Resident 7 had orders for: 1. Baclofen (muscle relaxant medication to treat muscle spasms) Oral Tablet, Give 20 milligrams (MG - a unit of measurement) every 6 hours for muscle spasms. 2. Methocarbamol (another muscle relaxant medication to treat muscle pain and spasms) Oral Tablet 1000 MG, give every 6 hours for muscle spasms. During an interview with Resident 7 on 8/14/2025 at 11:02 p.m., Resident 7 stated he received baclofen and methocarbamol late at least 3 times in the last month. Resident 7 stated when he receives baclofen and methocarbamol late it can cause the muscle spasms to be uncomfortable. During a review of Resident 7's Medication Administration Audit Report, dated 7/13/2025 to 8/15/2025, on 8/15/2025 at 12:05 p.m., the Report indicated Licensed Vocational Nurse (LVN) 7 administered the following medications late or too close to the previous dose to Resident 7: A. Baclofen:1. Scheduled for 7/13/2025 6:00 a.m. and administered on 7/13/2025 7:04 a.m.2. Scheduled for 7/17/2025 6:00 a.m. and administered on 7/17/2025 7:06 a.m.3. Scheduled for 7/20/2025 12:00 a.m. and administered on 7/20/2025 4:05 a.m.4. Scheduled for 7/20/2025 6:00 a.m. and administered on 7/20/2025 6:35 a.m. (only two and a half hours after the previous dose)5. Scheduled for 7/23/2025 12:00 a.m. and administered on 7/23/2025 1:02 a.m.6. Scheduled for 7/23/2025 6:00 a.m. and administered on 7/23/2025 7:04 a.m.7. Scheduled for 7/24/2025 12:00 a.m. and administered on 7/24/2025 1:03 a.m.8. Scheduled for 7/24/2025 6:00 a.m. and administered on 7/24/2025 7:20 a.m.9. Scheduled for 8/1/2025 12:00 a.m. and administered on 8/1/2025 1:35 a.m. B. Methocarbamol:1. Scheduled for 7/13/2025 6:00 a.m. and administered on 7/13/2025 7:04 a.m.2. Scheduled for 7/17/2025 6:00 a.m. and administered on 7/17/2025 7:06 a.m.3. Scheduled for 7/20/2025 12:00 a.m. and administered on 7/20/2025 4:05 a.m.4. Scheduled for 7/20/2025 6:00 a.m. and administered on 7/20/2025 6:35 a.m. (only two and a half hours after the previous dose)5. Scheduled for 7/23/2025 12:00 a.m. and administered on 7/23/2025 1:02 a.m.6. Scheduled for 7/23/2025 6:00 a.m. and administered on 7/23/2025 7:04 a.m.7. Scheduled for 7/24/2025 12:00 a.m. and administered on 7/24/2025 1:03 a.m.8. Scheduled for 7/24/2025 6:00 a.m. and administered on 7/24/2025 7:20 a.m.9. Scheduled for 8/1/2025 12:00 a.m. and administered on 8/1/2025 1:35 a.m. During a concurrent interview and record review with Registered Nurse (RN) 4 on 8/15/2025 at 2:52 p.m., Resident 7's medication administration audit report was reviewed. RN 4 stated medications can be given up to one hour before the scheduled time and up to one hour after the scheduled time. RN 4 stated if a medication is given later than 1 hour after the scheduled time, the nurse is to call the physician to notify and clarify when the next dose should be administered. RN 4 stated the administration of methocarbamol and baclofen on 7/20/2025 at 4:05 a.m. is too close to the next dose (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was administered on 7/20/2025 at 6:35 a.m. RN 4 stated the doctor should have been notified. RN 4 stated giving the medication too close together puts the resident at risk for receiving too much of the medication and potentially having an adverse effect. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4:10 p.m., the DON stated if medications are administered over one hour late, it can be a delay of care. If a resident receives baclofen and methocarbamol late, the resident can experience muscle spasms and be uncomfortable. If medications are administered too close to the previous administration, there is a risk for an adverse reaction. During a review of the facility's policy and procedure (P&P), titled Medication Administration, dated 1/1/2012, the P&P indicated to medications and treatments will be administered as prescribed to ensure compliance with dose guidelines and medications may be administered one hour before or after the scheduled medication time.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure accurate medical records for two of three residents (Resident 30 and 90) when the facility: A. Failed to ensure Certified Nurse Assistant (CNA) 5 accurately documented in Resident 30's chart. B. Failed to ensure Restorative Nurse Assistant (RNA) 2 accurately documented in Resident 90's chart. C. Failed to ensure RNA 2 documented the amount of time spent with the Resident 90, Resident 90's tolerance to service rendered, and signature initial of RNA providing the services in each occurrence. These deficient practices resulted in an inaccurate depiction of services and care rendered and lack of documentation in the medical record. Findings: A. During a review of Resident 30's admission record, the admission record indicated Resident 30 was initially admitted to the facility on [DATE] with diagnoses including cerebral ischemia (reduced blood flow to a part of the brain resulting in brain damage) and benign prostatic hyperplasia (BPH- enlarged prostate that can cause urinary problems such as pain or difficulty urinating.) During a review of Resident 30's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 8/6/2025, the MDS indicated Resident 30's cognition (ability to learn, reason, remember, understand, and make decisions) was intact, required supervision when eating and for oral hygiene, and required maximal assistance (helper does more than half of the effort) for toileting, bathing, and dressing. During a review of Resident 30's care plan initiated on 8/1/2025, the care plan indicated Resident 30 had potential nutritional problems and was at risk for malnutrition. During an interview with CNA 6 on 8/15/2025 at 1:06 p.m., CNA 6 stated he was assigned to Resident 30 on 8/15/2025. CNA 6 stated Resident 30 refused his lunch tray and offered a lunch alternative. During a concurrent interview and record review with CNA 5 on 8/15/2025 at 1:50 p.m., Resident 30's Nutrition Meal Intake &ndash; Amount Eaten documentation was reviewed. CNA 5 stated on 8/15/2025 at 1:31 p.m. she documented that Resident 30 ate 75% -100% of his lunch. CNA 5 stated she is not assigned to Resident 30, did not know how much Resident 30 ate for lunch because she did not observe his lunch tray. CNA 5 stated she documented for CNA 6 because CNA 6 had trouble logging in to the charting system. CNA 5 stated we should not document residents we are not assigned to or did not perform the task for. During an interview with the Director of Nursing (DON) on 8/15/2025 at 4:00 p.m., the DON stated it is not appropriate to document on a resident if you are not the person completing the task or making the observation. During a review of the facility's policy and procedure (P&P), titled Completion & Correction, revised 1/1/2012, the P&P indicated any persons making observations or rendering direct services to the resident will document in the record. facility staff may not sign for another person. B. and C. During a review of Resident 90's admission Record, the admission record indicated Resident 90 was originally admitted to the facility on [DATE] with diagnosis including chronic respiratory failure (a long-term condition where the respiratory system fails to maintain adequate gas exchange), dependent on a ventilator (a medical device to help support or replace breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	partial paralysis on one side of the body) affecting left non-dominant side. During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 90 was dependent (helper does all the effort to complete the task) on staff with all Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 90's Order printed 8/15/2025, the order indicated, 12/31/2024, RNA program for the following: a. Perform Active Assisted Range of Motion ([AAROM] resident uses the muscles around a weak joint to complete stretching exercises with the help of staff) to bilateral upper extremities (BUE) as tolerated, every day five times a week or as tolerated every dayshift (7 a.m. to 3 p.m.). b. Apply left Wrist-Hand-Finger Orthosis ([WHFO] device designed to support and immobilize the wrist, hand, and fingers) resting hand splint for up to two hours or as tolerated, every day 5 times a week or as tolerated every dayshift. c. Perform AAROM to bilateral lower extremities (BLE), every day five times a week or as tolerated every dayshift. d. Apply bilateral lower extremities (BLE) Pressure Relief Ankle Foot Orthoses ([PRAFOs] devices used to relieve pressure on the foot and ankle) for up to two hours every day 5 times a week or as tolerated every dayshift. During a review of Resident 90's Restorative Administration Record for 1/2025 to 3/2025, the Record indicated a check mark or an X mark on days RNA services were provided. The records did not indicate the amount of time spent with Resident 90, the initial of the nurse providing the RNA services, and tolerance to RNA services provided on each occurrence. During a concurrent interview and record review on 8/15/2025 at 2 p.m., with the Director of Staff Development (DSD), Facility Staffing sheets for 3/23/2025, 3/29/2025, and 3/30/2025 were reviewed. The DSD stated RNA 2 did not work on 3/23/2025, 3/29/2025, and 3/30/2025. During a concurrent interview and record review on 8/15/2025 at 2:12 p.m. with RNA 2, Resident 90's Restorative Administration Record for 1/2025 to 3/2025 were reviewed. RNA 2 stated she only mark the days RNA services were provided with a check mark or an X to indicate services were given and not the time amount spent with Resident 90 and the tolerance of Resident 90 with each service provided. The 3/2025 RNA Administration record was reviewed and the record indicated RNA 2 provided services on 3/23/2025, 3/29/2025, and 3/30/2025. RNA 2 stated she documented that she did the RNA services on 3/23/2025, 3/29/2025, and 3/30/2025 by mistake. RNA 2 stated she should not have documented by mistake. During an interview on 8/15/2025 at 4:00 p.m., with the Director of Nursing (DON), the DON stated documentation needs to be complete and accurate. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, revised 9/19/2019, the P&P indicated the RNA documents the amount of time the resident spent in the activity and their tolerance to the program. (continued on next page)		

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F 0842 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, Completion and Correction, revised 1/1/2012, the P&P indicated all services provided to the resident, or any changes in the resident's medical condition shall be documented in the resident's medical record. Documentation will be complete and accurate. Entries will include the date and signature as appropriate.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Infection Prevention Nurse (IPN) incorrectly identified residents to receive antibiotics (medication to treat infection) that did not meet Mc Geer's criteria (standardized tools with definitions for infections to aid if antibiotic use was appropriate) for two of three residents (Resident 11 and 47). This deficient practice resulted in the improper implementation of the antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinicians). Findings: A. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] with a gastrostomy tube ([G-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 11's Minimum Data Set ([MDS] a resident assessment tool) dated 8/7/2025, the MDS indicated Resident 11's cognition (ability to think and reason) was intact. The MDS indicated Resident 11 needed set-up assistance with eating, oral and personal hygiene, needed supervision with toileting hygiene, and partial assistance (helper does less than the effort to perform task) with showering. During a review of Resident 11's order dated 7/1/2025 at 3:21 p.m., the order indicated Bactrim DS (medication to treat infection) Oral tablet 800-160 milligram ([mg] unit of measurement), to give one tablet by mouth two times a day for a G-tube site abscess (localized collection of pus from a bacterial infection) for fourteen days. B. During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was originally admitted to the facility on [DATE] and recently readmitted on [DATE] with a diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a small open sore or wound), and muscle weakness. During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47's cognition was intact. The MDS indicated Resident 47 needed supervision with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 47's order dated 7/28/2025 at 9:47 p.m., the order indicated Cephalixin (medication to treat infection) tablet 500 milligrams, give one tablet by mouth three times a day for furuncle (painful, pus-filled lump caused by a bacterial infection) on the right armpit for ten days. During a concurrent interview and record review on 8/14/2025 at 2:59 p.m., with the Infection Prevention Nurse (IPN), the facility's Infection Prevention and Control Surveillance Log, 7/2025, was reviewed and the log indicated Resident 11 and Resident 47 did not meet Mc Geer criteria. The IPN stated Resident 11 and 44 both did not meet Mc [NAME] criteria. The IPN stated Residents 11 only had an abscess and there were no other symptoms. The IPN stated Resident 47 only had a furuncle and no other symptoms. During a concurrent interview and record review on 8/14/2025 at 3:02 p.m., with the IPN, the Wound Assessment, dated 7/1/2025, was reviewed and the assessment indicated Resident 11 complained of pain at the left upper mid abdomen area at the G-tube peristomal area (area of skin immediately surrounding a surgically created opening or stoma) and there was a visible abscess around the G-tube site. The wound had moderate serous drainage. The IPN stated according to this assessment Resident 11's antibiotic order met McGeer Criteria. During a concurrent interview and record review on 8/14/2025 at 3:10 p.m., with the IPN, Resident 47's eInteract Change of Condition Evaluation, dated 7/28/2025 at 8:07 p.m., was reviewed. The IPN stated the evaluation indicated Resident 47 had a furuncle in the right axilla (armpit) that was raised, erythematous (red and inflamed), warm to touch, and painful. The IPN stated based on this data Resident 47's ordered antibiotic met the McGeer Criteria. During an interview on 8/15/2025 at 4:00 p.m., with the Director of Nursing (DON), the DON stated the Mc Geer criteria need to be done correctly to ascertain appropriate infection surveillance and antibiotic stewardship. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, 5/20/2021, the P&P indicated the IPN was responsible (continued on next page)		

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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 08/15/2025
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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in ensuring whether the resident's condition meets the Mc Geer criteria when an antibiotic was ordered. During a review of the facility's Job description Manual titled, Infection Preventionist, undated, the Job Description indicated the IPN he serves as the facility's Infection Prevention and Control Officer, with oversight of the facility Infection Prevention and Control program. The IPN ensures adherence to evidenced based practice and professional guidelines.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to offer a pneumococcal vaccination (protects against pneumococcal disease, a serious infection that can cause pneumonia) for one of five sampled residents (Resident 95). This failure had the potential to result in Resident 95 contracting the pneumococcal disease. Findings: During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses including a history of COVID-19 and cerebral infarction (stroke - loss of blood flow to a part of the brain). During a review of Resident 95's Minimum Data Set ([MDS] a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 95's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 95 needed set-up assistance with eating, oral and personal hygiene, needed substantial assistance (helper does more than half the effort to complete the task) with showering. During a concurrent interview and record review on 8/13/2025 at 4:10 p.m., with the Infection Prevention Nurse (IPN), Resident 95's medical records were reviewed. The IPN stated there was no documented evidence Resident 95 was offered, educated on benefits and risks of the pneumococcal vaccine. During an interview on 8/15/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated residents need to be educated and offered the pneumococcal vaccine. During a review of the facility's policy and procedure (P&P) titled, Pneumococcal Vaccination - Pneumovax (PPSV23) or Pneumococcal conjugate vaccines (PCV13, PCV15 or PCV20), effective 5/4/2023, the P&P indicated the facility will provide all residents the opportunity to receive the pneumococcal vaccine, unless it is medically contraindicated, or the Resident is already immunized according to the Centers for Disease Prevention and Control recommendations or state/local public health guidelines.		