STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055077	A. Building B. Wing	03/31/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34180 Based on observation, interview, and record review, the facility failed to provide the resident, who attempted to get out of bed unsupervised and was at risk for falls, with supervision and interventions to prevent from falls and injury for one of two sampled residents (Resident 1). The facility failed to ensure: 1. Resident 1's care plan (CP) titled, 'The resident is high risk for falls' was reviewed after Resident 1's first fall, on 11/24/2021 to evaluate the effectiveness of care plan intervention and implement different intervention to safeguard the resident from future falls. 2. The staff conducted frequent periodic visual monitoring of Resident 1 to ensure the resident was safe as documented on Bed Rail Assessment and to specify the frequency of visual monitoring for staff to follow and as indicated in the resident's short-term care plan titled, Status Post ([S/P] condition after a treatment and/or procedure) unwitnessed fall. 3. Resident 1 had upper side rails up and padded to prevent the resident from injury due to diagnosis of seizure disorder as indicated in the facility's policy and procedure titled Bed Rails. 4. An Interdisciplinary Team ([IDT] a meeting with professionals to create a plan of care for residents) conducted Resident 1's assessment after the resident's first fall on 11/24/2021 as outline in the facility's policy and procedure titled 'Fall Prevention and Management Program.' Resident 1 had severely impaired cognitive skills (thought process) for daily decision-making, had diagnosis of quadriplegia (paralysis of all four limbs) with ventriculostomy (a surgical opening with a catheter placed to drain excess fluid from the brain) in place was receiving blood thinning medications (medications used to thin the blood and treat/prevent blood clots). These conditions placed Resident 1 at risk for falls, injuries, and bleeding. Resident 1 had two falls within four days and sustained a head injury. (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 0689 Level of Harm - Actual harm Residents Affected - Few	This deficient practice resulted in Resident 1 falling twice from the bed onto the floor and sustain a 6.0 centimeter ([cm] unit of measurement) right parietal (the area at the posterior end of the skull near the midline) subdural hematoma (a collection of blood on the brain due to injury or trauma). On 11/28/2021, Resident 1 was transferred to a general acute care hospital (GACH) where the resident was diagnosed with blunt head trauma ([BHT] head injury) and was admitted to the intensive care unit ([ICU] higher level of care) for five days. Findings: During a review of Resident 1's history and physical (H/P) from the GACH dated 9/17/2021, prior to admission to the facility, the H/P indicated Resident 1 had a traumatic (stressful, frightening or distressing events) brain injury requiring a ventriculostomy placement. The H/P indicated Resident 1 became a quadriplegic (permanent immobility of both arms and both legs) after a traumatic motor vehicle accident. The H/P indicated Resident 1 underwent multiple major surgeries and procedures and remained hospitalized for two months. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide [resulting in difficult breathing]) with a tracheostomy ([Trach] an opening in the windpipe), muscle weakness, dysphagia (difficulty swallowing), cognitive (thought process) communication deficit, traumatic subdural hemorrhage (blood collects between the brain surface and the skull), functional quadriplegic and epilepsy (abnormal brain activity that causes episodes of uncontrolled body jerking and loss of mental awareness). Resident 1 was receiving medical grade oxygen supplement via a T-collar (placed over the trach with humidified oxygen). During a review of Resident 1's Minimum Data Set (MDS), a standardized resident assessment and care-screening tool, dated 11/17/2021, the MDS indicated Resident 1 had severely impaired cognitive skills for daily decision making and required a total assistance with one-person physical assistance for bed mobility, transfers, toilet use and personal hygiene. The MDS indicated Resident 1 had impairment to both upper and lower extremities and did not utilize any mobility devices. During a review of Resident 1's Clinical Admission Evaluation (CAE), dated 11/10/2021 and timed at 4:50 p. m., the CAE indicated Resident 1 was disoriented (confused and unable to think clearly) with severely impaired cognition, paralysis, weakness and impairment to upper and lower extremities (arms/legs). During a review of Resident 1's Fall Risk Assessment (FRA), dated 11/10/2021 and timed at 4:50 p.m., the FRA indicated Resident 1 had a fall score of 12. According to the FRA, a total score of 10 or more indicated a high risk for falls. During a review of Resident 1's CP, dated 11/11/2021 and titled, The resident is high risk for falls related to deconditioning (process of body change with periods of inactivity, bedrest that results in loss of mental status, continence (ability to control bowel and bladder) and everyday activities) gait/balance problems, incontinence (inability to control bowel and bladder), poor communication/comprehension, unaware of safety needs, the care plan indicated the following staff's interventions: 1. Follow the facility's policy and procedure titled 'Fall Prevention and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Management Program.' 2. Place the resident on a low bed. 3. Place a call light within the resident's reach. 4. Place bilateral (both) floor mats on the floor. During a review of Resident 1's Bed Rail Assessment (BRA), dated 11/10/2021 the BRA indicated the following: 1. Resident 1 was non-ambulatory. 2. Resident 1 had fluctuating consciousness. 3. Resident 1 had alteration in safety awareness due to cognitive decline. 4. Resident 1 displayed poor bed mobility/difficulty moving in bed. 5. Resident 1 ad difficulty with balance and poor trunk control. The interventions included: 1. Lower bed to the floor. 2. Provided frequent staff monitoring at night. Side Rail Placement: None recommended and side rail assist bar not indicated at this time. During a review of an article last updated on 9/2/2021 and titled, Seizure Precautions, the article indicated under Ensuring Safety Precautions, to make sure the resident is in a bed with padded side rails for safety https://www.ncbi.[NAME].nih.gov/books/NBK536958/ During a review of Resident 1's CP, dated 11/11/2021 and titled, the resident is on anticoagulant (medication used to thin blood) therapy related to disease process and post-surgery, the care plan indicated the following staff's interventions: Resident/family/caregiver teaching to include take/give medication at the same time each day, use soft toothbrush use electric razor, avoid activities that could result in injury, take precautions to avoid falls, signs/symptoms of bleeding, avoid foods high in Vitamin K. A review of Resident 1 recapitulated physician's orders ([recap] order summary) for the month of 11/2021, the orders indicated Resident 1 was receiving the following medications: 1. Heparin (a medication used to treat and prevent blood clots) 5,000 units ([U] a unit of measurement) subcutaneous injection (injection of medication into the fatty tissue under the skin), every eight hours for deep vein thrombosis ([DVT] blood clot that forms in a deep vein). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Levetiracetam (medication to prevent and control seizures) 1,500 milligrams ([mg] unit of measurement), through the gastrostomy ([G-tube] a tube surgically placed into the stomach for feeding, medication, and hydration), twice daily for seizures. 3. Clobazam (medication used to treat seizures) 10 mg, through the G-tube, twice daily for seizure. 4. Eliquis (medication used to prevent serious blood clots) 5 mg, through the G-tube, twice daily for DVT. During a telephone interview on 3/24/2022 at 5:13 p.m., the Director of Nursing (DON) stated residents taking blood thinners and/or anticoagulants are prone to bleeding and any impact from injury, such as from fall, would cause them to bleed. The DON stated a fall could cause the resident to bleed. During a review of Resident 1's Skilled Evaluation Note (SEN), dated 11/23/2021 and timed at 10:48 a.m., the SEN indicated Resident 1 had mild cognitive impairment, was inattentive and required cues (signals, reminders). According to the SEN, Resident 1 was bedfast with an unsteady gait (to walk) and had poor balance (functional quadriplegic). During a review of Resident 1's Change of Condition (COC) note, dated 11/24/2021 and timed at 4:45 a.m., the COC note indicated at 4:30 a.m., on 11/24/2021, Resident 1 had an unwitnessed fall, and was found on the floor lying on his right side next to his bed with his legs still on the bed. The COC indicated Resident 1 was assisted back to bed, was assessed by a licensed nurse. Resident 1 did not sustain any physical injuries and the physician was notified. During a review of Resident 1's Post Fall Evaluation (PFE), dated 11/24/2021 and timed at 12:31 p.m., the PFE indicated Resident 1 had an unwitnessed fall from his bed on 11/24/2021 at 12 a.m. [sic]. The PFE indicated Resident 1 fell from his bed due to repositioning himself. The PFE indicated Resident 1 was found on the floor next to his bed with both legs still on the bed. During an interview on 3/3/2022 at 12:06 p.m., the DON stated on 11/24/2021, Resident 1 rolled out of his bed and fell on to the floor but was able to stand. The DON stated when Resident 1 fell on [DATE], there were no floor mats at the resident's bedside prior to 11/24/2021. The DON stated Resident 1 did not have any bed rails because the facility did not use bed rails. During a review of Resident 1's physician's order dated 11/24/2021 and timed at 6:45 a.m., the order indicated for Resident 1 to have a STAT (immediate) x-ray (a test that produces images of the structures inside of the body) of the skull, bilateral (both) shoulder, and a bilateral hip due to a fall. During a review of Resident 1's physician's order dated 11/24/2021 and timed at 7 a.m., the order indicated for Resident 1 to have bilateral landing pads (floor mats) on the floor for protection from injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's short-term CP, dated 11/24/2021 and titled, Status Post (S/P) unwitnessed fall, the care plan indicated the staff's interventions included to obtain orders for diagnostics x-ray to rule out (r/o) any fractures (broken bones) secondary to the fall, frequent visual check (the CP did not indicate a frequency for visual checks), floor mats as ordered, low bed at all times, and to access the need for a bed alarm. This care plan had no new interventions to prevent Resident 1 from falling. During a review of the facility's Incident Report (IR), dated 11/24/2021, the IR indicated when Resident 1 was asked what happened after he fell at 4:30 a.m., Resident 1 mouthed he wanted to go to the bathroom. During a review of the facility's Investigative Interview Report (IIR), dated 11/24/2021 and timed at 5:30 a.m., the IIR indicated the Respiratory Therapist 1 ([RT 1] a healthcare practitioner trained to provide respiratory care and treatment to individuals with lung conditions and diseases) while conducting routine morning treatments on 11/24/2021, found Resident 1 lying on the floor on his right side with his legs still on the bed. According to the IIR, RT 1 immediately reported Resident 1's fall to the Registered Nurse Supervisor 1 (RNS 1). During a review of Resident 1's SEN, dated 11/25/2021 and timed at 9:47 a.m., the SEN indicated Resident 1 made three attempts to get out of bed on 11/25/2021. The SEN indicated frequent visual checks was conducted. During a review of Resident 1's SENs there was no documented evidence of frequent visual checks/monitoring of Resident 1 conducted by the staff. During a telephone interview on 3/24/2022 at 5:20 p.m., the DON was asked about Resident 1's SEN dated on 11/25/2021 and timed at 9:47 a.m. and was asked how the staff conducted frequent visual checks/monitoring. The DON the facility did not have a protocol regarding the frequency of monitoring residents. The DON stated staff used their own perceptions of timeframe/frequency for visually monitoring residents. The DON stated the only visual monitoring document was when the CNAs documented ADL care. The DON was asked how often the staff monitored Resident 1 on 11/25/2021, the DON then stated every 15 minutes, but the staff did not document. During a review of Resident 1's SEN, dated 11/27/2021 and timed at 11:25 a.m., the SEN indicated the resident was confused and did not follow simple commands. The SEN indicated Resident 1 tried to get out of bed. During a review of Resident 1's COC note, dated 11/28/2021 and timed at 9:34 a.m., the COC note indicated Resident 1 had a second unwitnessed fall and was observed lying on a padded mattress, on the floor, on the left side of the bed. The COC note indicated Resident 1 was nonverbal and unable to explain what happened. The COC indicated Resident 1 did not sustain any physical injuries. During a review of Resident 1's PFE, dated 11/28/2021 and timed at 12:17 p.m., the PFE indicated Resident 1 had an unwitnessed fall from the bed on 11/28/2021 at 8:15 a.m. The PFE indicated Resident 1 fell from his bed due to repositioning himself. The PFE indicated Resident 1 was found on the floor next to his bed with both legs still on the bed. A review of Resident 1's physician's order, dated 11/28/2021 and timed at 9 a.m., the order indicated for the nursing staff to transfer Resident 1 to the GACH for further evaluation due to a fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Nurse's Progress Note (NPN), dated 11/28/2021 and timed at 12:24 p.m., the NPN indicated because of Resident 1's fall, the resident was transferred to another room closer to the nurses' station after the second fall, for frequent visual monitoring. The NPN indicated at 8:40 a.m., a physician's order was obtained to transfer Resident 1 to the hospital for further evaluation. The NPN indicated a private ambulance company was called and the estimated time of arrival to pick up Resident 1 was one to two hours. The NPN indicated at 11:15 a.m., Resident 1 was transported to the GACH by a private ambulance company. During a review of Resident 1's GACH Emergency Department (ED) H/P, dated 11/28/2021 and timed at 12:08 p.m., the H/P indicated Resident 1 was transported to the ED after being found on the floor by the facility's nursing staff. According to the H/P, the facility's nursing staff indicated Resident 1 was non-verbal and could not follow verbal commands. According to the H/P, Resident 1 had a computerized tomography ([CT scan] detailed pictures of parts of the body and the structures inside the body) of the brain due to trauma which resulted in a 6.0 cm right parietal subdural hematoma. The H/P indicated Resident 1 was admitted into the ICU unit for close monitoring for a total of five days and required treatment by a neurosurgeon (a physician that specializes in surgically treat disorders of the nervous system [brain and spinal cord] including trauma, tumors). During a review of Resident 1's Clinical Admission Evaluation (CAE), dated 12/2/2021 and timed at 6:30 p.m. , the CAE indicated Resident 1 was readmitted to the facility, was assessed as being confused, disoriented, required cues, due to severe impaired cognition with incoherent (unclear) speech and weakness and impairment to upper and lower extremities. During an interview on 12/15/2021 at 6:17 p.m., DON stated she did not investigate Resident 1's fall occurred on 11/28/2021 but did document a post-fall note for Resident 1. During an observation on 12/15/2021 at 6:30 p.m., Resident 1 was sitting in bed watching television with tracheostomy in place and with intact bandage to forehead. During an interview on 3/3/2022 at 12:06 p.m., DON stated after Resident 1's second fall on 11/28/2021, Resident 1 was transferred to the hospital because he was receiving blood thinners (medications), sustained a hematoma, and was hospitalized . The DON stated Resident 1 was assessed upon the initial admission to the facility as being at risk for falls. The DON was asked how the facility's staff would prevent Resident 1 from recurrent falls. The DON stated after the second fall on 11/28/21 Resident 1 was moved to a room closer to the nursing station so the nurses could visually monitor Resident 1. During a concurrent interview and review of Residents 1's SEN with the DON on 3/3/2022 at 1:29 p.m., the DON was asked about Resident 1's SEN, dated 11/25/2021 and timed at 9:47 a.m., indicating Resident 1 made three attempts to get out of bed and received frequent visual checks. The DON was asked did the staff prevent Resident 1 from attempting to get out of bed and falling. The DON stated Resident 1 was moved to a room closer to the nursing station on 11/28/2021 and after Resident 1's second fall. The DON stated the nurses were not always sitting at the station. The DON was asked how often the staff performed frequent visual checks and did the staff document the visual checks, the DON stated the staff checked Resident 1 as often as they could. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/4/2022 at 4:35 p.m., Registered Nurse 2 (RN 2) stated that on 11/28/2021, Resident 1 had an unwitnessed fall and was found on the floor and sent to the hospital. RN 2 stated when Resident 1 was initially admitted to the facility he was weak and was diagnosed as a quadriplegic but could move and dangle his legs. RN 2 stated he was unsure if Resident 1 had floor mats, because floor mats were considered a restraint. RN 2 stated Resident 1 was moved to a room closer to the nursing station when he returned from the hospital due to the second fall. During a telephone interview on 3/9/2022 at 4:02 p.m., Certified Nursing Assistant 1 (CNA 1), stated she was assigned to Resident 1 on 11/28/2021. CNA 1 stated Resident 1 tried to get out of bed and sat on the side of the bed on several occasions. CNA 1 stated Resident 1 was weak and a fall risk. CNA 1 stated Resident 1 did not have a sitter and she was instructed to check on Resident 1 but with no specific timeframe. CNA 1 stated she would check on Resident 1 whenever she passed by Resident 1's room and was unsure how often she conducted visual checks. During a telephone interview on 3/24/2022 at 4:48 p.m., the DON was asked about Resident 1's bed rail assessment dated on 11/10/2021 and timed at 4:50 p.m. The DON stated Resident 1 did not require bed rails on because bed rails caused entrapment. The DON stated if Resident 1 had a seizure his legs and/or hands could get caught in the side rail. The DON stated there were no seizure precautions in place for Resident 1, but the goal was to prevent Resident 1 from injury. The DON stated seizure precautions included a low bed, floor mats and pillows on the side of the bed. According to the DON, the licensed nurse who conducted Resident 1's bed rail assessment indicated Resident 1 did not require bed rails because the resident had a trach and a G-tube. The DON stated Resident 1 was re-assessed for utilizing bed rails on 12/2/2021 and on 12/2/2021, side-rails were not indicated for Resident 1. The DON asked which seizure precautions were utilized for Resident 1, the DON stated a low bed and floor mats. The DON stated she has cared of a seizure resident in over [AGE] years and there were no in-services provided to the staff regarding residents with seizure disorders. The DON stated Resident 1 was not on seizure precautions because the resident did not have any seizure activity, his seizures were not real, and the resident was on seizure medication. During a telephone interview on 3/28/2022 at 2:17 p.m., the DON stated the facility had not used bed alarms for over a year. The DON stated the bed alarms had the same alarm sound as the ventilator (a machine that helps you breathe or breathes for you) alarms and the sound was misleading and would confuse the staff. The DON asked about the risk for fall prevention for the residents who moved around in bed and attempted to get out of bed, the DON stated the staff would attend to those residents as quickly as possible by conducting visual checks for at least every 15 to 30 minutes. During a review of the facility's revised policy and procedure (P/P), dated 8/1/2014 and titled, Fall Prevention and Management Program the P/P indicated for the facility to provide a safe environment that minimizes complications associated with falls. The P/P indicated the IDT would initiate, review, and update fall risks and plan of care at the following intervals: admission, quarterly, annually, upon significant change of condition identification and post fall. The P/P indicated the Licensed Nurses would evaluate the resident's response to the plan of care during weekly summary evaluation and update the resident's care plan as necessary. During a telephone interview on 3/28/2022 at 2:25 p.m., DON stated there was no IDT conducted on Resident 1 after the resident's fall on 11/24/2021 and 11/28/2021. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's revised P/P, dated 12/4/2021 and titled, Bed Rails the P/P indicated the facility will adequately evaluate the use of bed rails and prevent potential entrapment or other safety hazards. The P/P indicated a bed rail is an assistive device and must be used in only to treat a resident's medical symptoms. The P/P indicated a padded bed rails will be used to prevent injury to the resident in case of uncontrolled (unable to control and/or stop) movement. During a review of the facility's revised P/P, dated 1/1/2012 and titled, Seizure Precautions the P/P indicated during admission, residents will be evaluated for potential for seizure activity and findings will be documented in the resident's care plan. The P/P indicated if the resident has potential for seizure activity, the resident's room will be prepared accordingly.