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	07/13/2021

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36504 Based on observation, interview and record reviews, the facility failed to ensure hand mittens (a glove covering the whole left hand) were not used on 2 of 3 sampled residents (Residents 66 and 67) as a physical restraint to stop the residents from pulling out the gastrostomy tube (G-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach) and scratching the staff during care, without first attempting least restrictive measures. a. Resident 66 had no orders, assessment, and care plans for the use of hand mittens/physical restraints. b. Resident 67 had no reassessment to continue the use of restraints and no monitoring was found for the use of the hand mittens for the months of 5/2021 and 6/2021. These deficient practices resulted in an unnecessarily restricting Resident 66 and prevent him from using his right hand and Resident 67 being on physical restraint longer than necessary. Findings: a. During an observation on 7/7/2021 at 9:30 a.m., Resident 66 was observed with a hand mitten on the right hand. During a review of Resident 66 Admission Record (Face Sheet), the face sheet indicated Resident 66 was admitted to the facility on [DATE]. Resident 66 diagnoses included dysphagia (difficulty in swallowing food or liquids), respiratory failure (a condition in which the blood does not have enough oxygen), contracture left elbow, tracheostomy [an opening surgically created through the neck into the trach (wind pipe)] and gastrostomy (an opening surgically created into the stomach through the abdomen). During a review of Resident 1's Minimum Data Set (MDS) a standardized assessment and care screening tool, dated 4/15/2021, indicated Resident 1's was severely impaired in cognitive skills for daily decision making and needed total assistance from staff for bed mobility, transfer, dressing, eating and hygiene. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/7/2021 at 11:20 a.m., Certified Nursing Assistance (CNA 4), stated she changed the mitten on Resident 66 with a clean one because the old green one was dirty. CNA 4 stated Resident 66 had the hand mitten to prevent him from scratching the staff during care. During an interview on 7/8/2021 at 3:55 p.m., the Director of Nursing (DON) stated she was aware Resident 66 had a hand mitten to his right hand to prevent him from pulling the G-tube out. During an interview and review of Resident 66's physician orders on 7/8/2021 at 4:14 p.m., the Assistance Nurse Director (ADON) stated and confirmed there were no physician orders for 7/2021 indicating and order for Resident 66 to be on hand mittens. The ADON stated there was no assessment documented on Resident 66's use of the hand mittens and no care plan developed for the use of the hand mittens/restraints. The ADON stated being aware Resident 66 was on physical restraint (hand mitten) but was not aware there was no physician order for its use. During an interview on 7/13/2021 at 9:08 a.m., the DON stated she was not aware Resident 66 had no physician orders for the hand mittens. DON stated the facility policy and procedure for restraint was before applying any form of physical restraint, the facility should try the less restrictive alternatives, such as distractions, increase in activity, placing resident on 1:1 monitoring and use of abdominal binder if resident is trying to pullout G tube. The DON stated there should be a physician order and informed consent from the resident or family before the physical restraints are used, a plan of care should be developed and implemented while resident is on physical restraints. The DON stated residents on restraints should be re-assessed daily for possible discontinuation of their use. During an interview on 7/13/2021 at 10 a.m., Director of Staff Developer (DSD) stated only trained license nurse should be applying physical restrain on residents and should be monitored every 2 hours for the effectiveness and continuation of the restraint. 36926 b. During a review of Resident 67's Admission Record, the record indicated Resident 67 was admitted to the facility on [DATE]. Resident 67's diagnoses included G-tube and dementia (a progressive loss of brain function affecting memory, thinking, and behavior that interferes with daily functioning). During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67's cognition was severely impaired. The MDS indicated Resident 67 required total assistance with bed mobility, dressing, eating, toileting, bathing, and the resident's vision was severely impaired. During a review of Resident 67's physician orders, dated 11/6/2020, the orders indicated staff could use hand mittens on the right hand to prevent pulling out G-tube (not to exceed 2 hours hand mitten), release for every 15 minutes after 2 hours. The orders indicated to monitor placement of right-hand mitten every shift and monitor the resident's hand for signs and symptoms of discoloration and/or skin breakdown, and signs and symptoms of impaired circulation. During a review of Resident 67's Medication Administration Records (MAR), dated May 2021, June 2021, and July 2021, the MARs indicated facility staff applied a hand mitten to Resident 67's right hand every day. The MARs dated May 2021 and June 2021 did not indicate Resident 67's right hand was monitored for signs and symptoms of discoloration and/or skin breakdown and signs and symptoms of impaired circulation as ordered. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's Physical Restraint Device Assessment, dated 1/27/2021, the assessment indicated Resident 67 had a right-hand mitten and the facility would continue to use the mitten to prevent resident from pulling out the G-tube. The facility was unable to locate or determine if any additional physical restraint device assessments had been done since 1/27/2021. During a concurrent observation and interview on 7/06/2021 at 10:37 a.m., Resident 67 was observed lying in bed with a blue mitten covering the Resident's entire right hand. When asked why Resident 67 had a mitten covering the right hand, Certified Nursing Assistant (CNA 2), stated Resident 67 had the mitten so she didn't pull out her G-tube. During a concurrent interview and record review on 7/8/2021 with Licensed Vocational Nurse (LVN 7), LVN 7 reviewed Resident 67's medical record and stated it looked like Resident 67 had the hand mitten restraint to prevent her from pulling out the G-tube. LVN 7 stated the last restraint assessment for Resident 67 was done on 1/27/2021. LVN 7 stated he thought the restraint assessments were usually done quarterly, but he was not sure. During an interview on 7/12/2021 at 7:35 a.m., with Medical Records staff (MedRec), MedRec looked through Resident 67's medical record and stated she did not see any recent restraint assessment or interdisciplinary team [IDT] a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) meeting notes for Resident 67. MedRec stated it looked like the last physical restraint assessment was done on 1/27/21. MedRec stated she would continue to look and see if she could find any recent documentation related to Resident 67's hand mitten restraint. During an interview on 7/13/21 at 9:08 a.m. with the Director of Nursing (DON), when asked how often residents should be re-assessed for the continued use of physical restraints, the DON stated she did not know what the facility policy indicated, but she thought they had to re-assess the residents in restraints as much as they could, maybe a month or two or even after a week. When asked when the last time was the facility re-assessed Resident 67 for the use of hand mitten restraints, the DON stated she did not know since she was new to the facility. During a review of the facility's policy and procedure (P&P) titled Restraints, revised on of 1/1/2012, the P&P indicated restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. The P&P indicated restraints required a physician order and informed consent from resident before initiating the restraint. The policy further indicated if a physical restraint was used, the licensed nurse will document in the resident's care plan; the medical symptoms requiring the use of restraints, treatment team goals in use of the restraint, systematic and gradual approaches for minimizing or eliminating the concerning behavior and restraint use, the type of restrain and the time it was used, while restrain was in use, the nurse's approach will include frequent observation, release of restrain every 2 hours for toileting and reposition, checking for circulation and condition of the skin.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44563 Based on interviews and record review, the facility failed to implement its policy and procedures (P/P) when discharging one of three sampled residents (Resident 57) by not ensuring the discharge of Resident 57 was completed and documented to indicate the discharge summary. This deficient practice resulted in Resident 57's health information not given to the receiving facility and not receiving all his belongings. Findings: During a review of Resident 57's Admission Record (Face Sheet), the face sheet indicated Resident 57 was admitted to the facility on [DATE] for hospice care (care for people in the last phases of a disease so that they may live as fully and comfortably as possible) and was discharged on [DATE]. Resident 57's diagnoses included chronic kidney disease ([CKD] condition in which the pressure in the blood is too high caused by the organ in the body that filters excess waste fluid from the blood), presence of urogenital implants (injections of materials into the opening of the tube through in which urine leaves the body to help control urine leakage), and unspecific malignant neoplasm of the skin (a condition in which cells grows uncontrollably and can invade other organs in your body). During a review of Resident 57's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/20/2021, the MDS indicated Resident 57's was cognitively intact (ability to think, understand and make decisions of daily living). During a review of Resident 57's Discharge Planning Assessment, dated 6/4/2021, the record indicated, Resident 57 desire and expected to be discharged near resident's family in an assisted living. During a review of Resident 57's progress notes for the month of 6/2021, there were no documentation a licensed nurse gave report to the receiving facility's licensed nurse upon Resident 57's discharge. During an interview on 7/9/2021, at 12:25 p.m., Licensed Vocational Nurse 4 (LVN 4) stated she was responsible to give report to the receiving facility's Registered Nurse (RN) when a resident was discharged from the facility. LVN 4 stated she was responsible to fill out the Discharge Summary Form for discharge instruction to the resident, but she forgot to complete it and document it prior to the discharge. During a concurrent interview and review on 7/9/2021, at 12:30 p.m., LVN 4 stated there were no documentation in Resident 57's discharge summary a report was given to the receiving facility when the resident was discharged . During a review of Resident 57's Discharge Transfer Summary Report for the month of 6/2021, there were no documentation a licensed nurse gave report to another licensed nurse to the receiving facility when Resident 57 was discharged from the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and review of the Discharge Summary on 7/9/2021, at 11:21 a.m., the Assistant Director of Nursing (ADON) stated when the resident is discharged to another facility, the charge nurse is supposed to give report to a licensed nurse from the receiving facility and document it in the resident's medical record titled, Discharge Transfer Summary Report. The ADON stated there were no documentation in Resident 57's progress notes for the month of 6/2021 of a licensed nurse given report to the receiving facility when the resident was discharged . During a review of Resident 57's Resident Inventory, dated 4/13/2021, the record indicated no documentation of Resident 57's signature indicating Resident 57 received all personal items accounted for on the day of discharge. During an interview on 7/9/2021, at 10:51 a.m., Certified Nursing Assistant 9 (CNA 9) stated it was the CNA's responsibility to complete the Resident Inventory sheet upon admission and transfer indicating the quantity of each piece of clothing items and other personal items were accounted for. CNA 9 stated the resident or the representative party must sign the same form with the discharge date as a receipt to indicate the resident or the representative party agreed all individual items has been accounted for. During a review of facility's P/P titled, Discharge and Transfer of Resident, dated 2/2018, the P/P indicated when the resident is going to be discharged , the licensed nurse will document a discharge summary for each resident in which will include a summary of the resident's stay and status in the resident's medical record. During a review of facility's P/P titled, Discharge and Transfer of Resident, dated 2/2018, the P/P indicated at the time of discharge, the facility staff will prepare the resident's inventory and provide the resident or resident representative a copy of the resident's inventory with the recipient signed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39085 Based on interview and record review the facility failed to inform and provide a seven-day bed hold notification for one of one resident (Resident 37) prior to a general acute care hospital (GACH) transfer. This deficient practice had the potential to cause psychosocial harm for Resident 37 and the resident's representative due to not knowing Resident 37 could return to the facility upon discharge from the GACH and violated resident's right to be readmitted into the facility. Findings: During a review of Resident 37's admission record, the record indicated Resident 37 was readmitted to the facility on [DATE]. Resident 37's diagnoses included hypertension (high blood pressure), dependence on respirator (mechanical life support because of inability to breathe effectively) and chronic obstructive pulmonary disease (a lung disease that causes obstructed airflow, and difficulty breathing). During a review of Resident 37's Minimum Data Set (MDS) a standardized assessment and care planning tool), dated 5/24/2021, the MDS indicated Resident 37 was cognitively (ability to make decisions of daily living) intact, and physically dependent for activities of daily living (getting dressed, toileting and personal hygiene). During a review of Resident 37's document titled, Progress Notes, dated 4/23/2021 and timed at 12:43 a.m., the note indicated a physician's order to transfer Resident 37 to a GACH due to desaturation (below normal level of oxygen [an odorless gas that is present in the air and necessary to maintain life] concentration in the blood). During a concurrent interview and review of Resident 37's medical record, the Assistant Director of Nursing (ADON) acknowledged there was no record a seven-day bed hold notice was given to Resident 37 or her legal representative prior to the transfer. The ADON stated it was important for all resident's being transferred out of the facility to be aware their bed would be available upon their return from the GACH. During a review of the undated facility's policy titled, Bed Hold, the P/P indicated the purpose was to ensure the resident and/or his/her representative was aware of the facility's bed-hold policy, and such policy complied with state and federal law and regulation. The facility will notify the resident and/or representative, in writing, of the bed hold option, any time the resident is transferred to an acute care hospital.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36504 Based on interview and record review, the facility failed to complete and encoded (entering information into the facility minimum data set [MD'S, a federally mandated comprehensive assessment tool used for care planning] software in the computer) residents assessment for eight of 22 sampled residents (Residents 3, 4, 5, 7, 10, 13, 16, and 20). These deficient practices had the potential to prevent the facility from monitoring each resident's decline or progress to be assessed correctly. Findings: During an annual recertification survey on 7/12/2021 the following residents' MDS were reviewed for completion and submission timeframe. Resident 3 MDS was last completed and submitted on 2/9/2021 Resident 4 MDS was last completed and submitted on 2/9/2021 Resident 5 MDS was last completed and submitted on 2/9/2021 Resident 7 MDS was last completed and submitted on 2/15/2021 Resident 10 MDS was last completed and submitted on 2/16/2021 Resident 13 MDS was last completed and submitted on 2/25/2021 Resident 16 MDS was last completed and submitted on 2/25/2021 Resident 20 MDS was last completed and submitted on 3/3/2021 During an interview on 7/12/2021 at 10:50 a.m., the MDS nurse, stated the facility was late in completion and submission of these resident's MDS because the facility was in transitioning to a new computer system and the new system was not user friendly. During an interview on 7/12/2021 at 12:30 p.m., the Administrator (ADM) stated he was not aware the facility was late in completion and submission of the MDS. During a review of the [NAME] presented by the facility CMS Form indicated the waiver given to the facility on MDS completion and submission ended on 4/8/2021. During a review of the facility's policy and procedure (P&P) titled, RAI (Resident Assessment Instrument) Process, revised on 10/4/2016, the RAI Process indicated the purpose was for the facility to provide resident assessments that accurately depict and identify resident issues and objectives as required, while meeting State and Federal and data submission requirements.

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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** 36504 Based on observation, interview and record reviews, the facility failed to ensure one of three sampled residents (Resident 66) with hand mitten (a glove covering the whole left hand) were assessed, use of less restrictive measures, and obtained a physician order before applying hand mitten as a physical restraint (any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) to stop the resident from pulling out the gastrostomy tube (G-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). These deficient practices resulted in an unnecessarily restricting Resident 66 and prevent him from using his right hand. Findings: During an observation on 7/7/2021 at 9:30 a.m., Resident 66 was observed with a hand mitten on the right hand. During a review of Resident 66 Admission Record (Face Sheet), the face sheet indicated Resident 66 was admitted to the facility on [DATE]. Resident 66 diagnoses included dysphagia (difficulty in swallowing food or liquids), respiratory failure (a condition in which the blood does not have enough oxygen), contracture left elbow, tracheostomy [an opening surgically created through the neck into the trach (wind pipe)] and gastrostomy (an opening surgically created into the stomach through the abdomen). During a review of Resident 1's Minimum Data Set (MDS) a standardized assessment and care screening tool, dated 4/15/2021, indicated Resident 1's was severely impaired in cognitive skills for daily decision making and needed total assistance from staff for bed mobility, transfer, dressing, eating and hygiene. During an interview on 7/7/2021 at 11:20 a.m., Certified Nursing Assistance (CNA 4), stated she changed the mitten on Resident 66 with a clean one because the old green one was dirty. CNA 4 stated Resident 66 had the hand mitten to prevent him from scratching the staff during care. During an interview on 7/8/2021 at 3:55 p.m., the Director of Nursing (DON) stated she was aware Resident 66 had a hand mitten to his right hand to prevent him from pulling the G-tube out. During an interview and review of Resident 66's physician orders on 7/8/2021 at 4:14 p.m., the Assistance Nurse Director (ADON) stated and confirmed there were no physician orders for 7/2021 indicating and order for Resident 66 to be on hand mittens. The ADON stated there was no assessment documented on Resident 66's use of the hand mittens and no care plan developed for the use of the hand mittens/restraints. The ADON stated being aware Resident 66 was on physical restraint (hand mitten) but was not aware there was no physician order for its use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/13/2021 at 9:08 a.m., the DON stated she was not aware Resident 66 had no physician orders for the hand mittens. DON stated the facility policy and procedure for restraint was before applying any form of physical restraint, the facility should try the less restrictive alternatives, such as distractions, increase in activity, placing resident on 1:1 monitoring and use of abdominal binder if resident is trying to pullout G tube. The DON stated there should be a physician order and informed consent from the resident or family before the physical restraints are used, a plan of care should be developed and implemented while resident is on physical restraints. The DON stated residents on restraints should be re-assessed daily for possible discontinuation of their use. During an interview on 7/13/2021 at 10 a.m., Director of Staff Developer (DSD) stated only trained license nurse should be applying physical restrain on residents and should be monitored every 2 hours for the effectiveness and continuation of the restraint. During a review of the facility's policy and procedure (P&P) titled Restraints, revised on of 1/1/2012, the P&P indicated restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. The P&P indicated restraints required a physician order and informed consent from resident before initiating the restraint. The policy further indicated if a physical restraint was used, the licensed nurse will document in the resident's care plan; the medical symptoms requiring the use of restraints, treatment team goals in use of the restraint, systematic and gradual approaches for minimizing or eliminating the concerning behavior and restraint use, the type of restrain and the time it was used, while restrain was in use, the nurse's approach will include frequent observation, release of restrain every 2 hours for toileting and reposition, checking for circulation and condition of the skin. During a review of the facility policy and procedure (P&P) titled Care Planning, revised on 11/2016, indicated the facility will provide a person-centered, comprehensive and interdisciplinary care plan that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44563 Based on interviews and record review, the facility failed to document a discharge summary, including an understanding of discharged medications and a post-discharge plan of care in one of three residents (Resident 57) medical record. This deficient practice had the potential to result in Resident 57 and his Responsible Party to not understand the specifications of the medications after being discharge from the facility and for Resident 57 to not receive the medications as prescribed. Findings: During a review of Resident 57's Admission Record (Face sheet), the face sheet indicated Resident 57 was admitted to the facility on [DATE] for hospice care (care for people in the last phases of a disease so that they may live as fully and comfortably as possible) and was discharged on [DATE]. The resident's diagnosis included hypertensive chronic kidney disease (a condition in which the pressure in the blood is too high caused by the organ in the body that filters excess waste fluid from the blood), presence of urogenital implants (injections of materials into the opening of the tube through in which urine leaves the body to help control urine leakage), and unspecific malignant neoplasm of the skin (a condition in which cells grows uncontrollably and can invade other organs in your body). During a review of Resident 57's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/20/2021, the MDS indicated Resident 57's was cognitively intact (ability to think, understand and make decisions of daily living). During a review of Resident 57's progress note for the month of 6/2021, there were no documentation of a discharge summary indicating Resident 57's final status, overall stay while in the facility or discharge education given to Resident 57 or Resident 57's Responsible Party. During a review of Resident 57's Discharge Transfer Summary Report for the month of 6/2021, the discharge summary indicated there were no documentation of a discharge summary indicating Resident 57's final status and overall stay while in the facility. During an interview on 7/9/2021, at 12:25 p.m., the Licensed Vocational Nurse 4 (LVN 4) stated, I am responsible to fill out the Discharge Summary Form for discharge instruction that includes medication . assessment of the skin and vitals. LVN 4 stated, It was my fault I didn't check to see if the discharge summary or progress note was completed or done on that day when the resident (Resident 57) was discharged . It is frustrating because I cannot believe I missed this. During a concurrent interview and record review on 7/9/2021, at 12:30 p.m., LVN 4 stated there were no documentation in Resident 57's medical record of a discharge summary when the resident was discharged . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/2021, at 11:21 a.m., the Assistant Director of Nursing (ADON) stated, when the resident was discharged to another facility, the charge nurse or the ADON was responsible to provide discharge instruction to the resident or responsible party and document it in the resident's progress notes or in the Discharge Summary Form. The ADON stated and confirmed there were no documentations of Resident 57's discharge. During a review of facility's policy and procedure (P/P) titled, Discharge and Transfer of Resident dated, 2/2018, the P/P indicated, when the resident is going to be discharged , the licensed nurse will document a discharge summary for each resident in which will include a summary of the resident's stay and status in the resident's medical record.

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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** 36926 Based on interview and record review, the facility failed to notify one of one resident (Resident 61) physician about laboratory test results promptly, as per facility policy. Resident 61 had a laboratory test for valproic acid level (form of valproate, a medication used to treat residents with seizure disorders) done on 6/4/2021 and the results indicated a level of 26 (normal range 50-100). This deficient practice resulted in Resident 61's physician not being notify of the abnormal laboratory results until five (5) days later on 6/9/2021, and had the potential to delay care and treatment, which could have caused Resident 61 to have a seizure. Findings: During a review of Resident 61's Admission Record (Face Sheet), the3 face sheet indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included: epilepsy (a neurological disorder causing seizures or periods of unusual behavior and sensations), bipolar disorder (a brain disorder that causes unusual shifts in mood, energy, activity levels), and Parkinson's disease (a disorder of the brain that leads to shaking [tremors] and difficulty with walking, movement, and coordination). During a review of Resident 61's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/21/2021, the MDS indicated Resident 61's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was intact. The MDS indicated Resident 61 required limited assistance with bed mobility, dressing, toileting, and supervision with bathing. During a review of Resident 61's Medication Administration Record (MAR), dated July 2021, the MAR indicated Resident 61 had received Divalproex Sodium (valproate) for seizure disorder. During a review of Resident 61's monthly drug regimen review (MRR), dated 5/2021, the MRR indicated the consultant pharmacist had requested a valproic acid laboratory test be done on Resident 61. The MRR indicated Resident 61's physician reviewed the pharmacist's recommendation and agreed. During a concurrent interview and record review on 7/12/2021 at 4:02 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 61's medical record and stated the valproic acid laboratory test was done on 6/2/2021, but no one called the doctor until 6/9/2021. ADON stated Resident 61 was taking the valproate for seizures. When asked what could happen if the valproate level is below normal, the ADON stated Resident 61 could have a seizure. During a concurrent interview and record review on 7/13/2021 at 10:20 a.m., with the Director of Nursing (DON), the DON stated that she expected her licensed staff to notify the physician right away if a lab result is out of range. DON looked the facility policy for laboratory services and stated the policy indicated to notify the doctor promptly. When asked what promptly meant, DON stated, That means as soon as they receive the result in their hands. (continued on next page)

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F 0684 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, Laboratory Services, dated 1/1/2012, the P/P indicated the licensed nurse would promptly notify the attending physician of laboratory test findings.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36926 Based on interview and record review, the facility failed to ensure one of one resident (Resident 61) received assistance with communication and hearing abilities to maintain Resident 61's functional interaction with direct care staff and visitors. Resident 61's hearing aids were lost in 1/2021, however, the facility did not follow-up on the order for replacement hearing aid until 7/7/2021 (7 months after). This deficient practice resulted in Resident 61 unable to communicate her needs with care staff and had the potential to decline in communication, cause emotional distress, and to affect the activities of daily living (ADLs). Findings: During a review of Resident 61's Admission Record (Face Sheet), the face sheet indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included epilepsy (a neurological disorder causing seizures or periods of unusual behavior and sensations), bipolar disorder (a brain disorder that causes unusual shifts in mood, energy, activity levels), and Parkinson's disease (a disorder of the brain that leads to shaking [tremors] and difficulty with walking, movement, and coordination). During a review of Resident 61's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/21/2021, the MDS indicated Resident 61's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was intact. The MDS indicated Resident 61 required limited assistance with bed mobility, dressing, toileting, and supervision with bathing. The MDS indicated Resident 61 had difficulty hearing and used hearing aids. During a review of Resident 61's care plan, dated 1/20/2021, the care plan indicated to ensure hearing aids were in place and in good working order. During a record review of Resident 61's Theft/Loss Report, dated 1/20/2021, the report indicated the facility was aware of the lost hearing aids and would pay for and replace the hearing aids. During a review of Resident 61's Psychological Consultation (services provided by a skilled professional counselor to an individual, family, or group for the purpose of providing well-being, alleviating stress, and enhancing coping skills) report, dated 6/18/2021, the report indicated Resident 61 had expressed she still couldn't hear, and it made hard every day. The consultation report indicated the psychologist followed-up with the facility regarding Resident 61's request for hearing aids. During an interview on 7/06/2021 at 10:24 a.m., Resident 61 stated she was gone from the facility in 12/2020 and when she came back in 1/2021, she could not find her hearing aids. Resident 61 stated it was difficult for her to hear and she usually wore a hearing aid in both ears. Resident 61 stated she thought the facility knew about it, but she had not heard back from anyone. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of Resident 61's hearing aid order, on 7/12/2021 at 11:36 a.m. the Social Services Director (SSD) stated the facility was aware Resident 61 lost her hearing aids in 1/2021 and the facility had agreed to replace them. The SSD stated the facility had placed an order for a new pair of hearing aids for Resident 61 on 1/2021. The SSD presented a fax, dated 1/21/2021, indicating a request to start the process for ordering replacement of Resident's 61's hearing aids, but did not follow up with the order of Resident 61's hearing aids. The SSD stated she placed a second replacement order after the survey team inquired about Resident 61's hearing aids on 7/7/2021. During a review of the facility's policy and procedure (P/P), titled, Theft and Loss, dated 7/11/2017, the P/P indicated the facility would assist residents in safeguarding their personal property and when personal property was missing, social services staff would investigate and resolve.

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F 0686 Level of Harm - Minimal harm or potential for 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** 41489 Based on observation, interview, and record review, the facility failed to reposition and redistribute pressure away from bony areas for one of eight sampled residents (Resident 53). Resident 53, who was at risk for developing pressure ulcers (damage to skin or underlying tissue that usually occurs over a bony area as a result of long term pressure) due to risk factors which included Impaired/decreased mobility, decreased functional ability, and history of a previously healed Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone. Slough [dead tissue] may be visible). This deficient practice had the potential to cause Resident 53 to develop adverse skin conditions and pressure ulcers. Findings: During a review of Resident 53's admission record, the admission record indicated Resident 53 was admitted to the facility on [DATE]. Resident 53's diagnoses included quadriplegic cerebral palsy (disease that affects all for limbs, the trunk, and face. The disease affects a person's ability to move and maintain balance and posture), stage 4 pressure ulcer of left buttock (healed), muscle weakness, contracture (condition of shortening and hardening of muscles, tendons, or other tissue often leading to deformity and rigidity of joints), cramps and spasms. During a review of Resident 53's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 6/26/2021, it indicated Resident 53 had no cognitive (thought) impairment. The MDS also indicated Resident 53 had impairment in both upper and lower extremities which interfered with daily functions. The MDS indicated Resident 53 was at risk for pressure ulcers. During a review of Resident 53's care plan, reviewed 3/29/2021 and titled, Resident at Risk for Skin Break/Ulcer Formation, the care plan indicated staff should assist with turning and repositioning and encourage turning and repositioning as applicable. During a concurrent observation and interview on 7/07/2021 at 10:21 a.m. Resident 53 was observed in bed in supine position with the head of the bed at 90 degrees and with pillows under his calves to elevate his feet off the bed. Resident 53 stated, I have not been turned or adjusted since 7 a.m. My CNA (certified nursing assistant) fed me and set me up for shower but did not turn or adjust me. During an interview on 7/08/2021 at 10:04 a.m., Resident 53 stated, Yesterday after I had my shower, they did not turn me for the rest of the shift. The evening shift adjusted me, and the night shift turned me. The only reason why they turned me today is because they put my splints on my legs at 7 a.m. During a concurrent observation and interview on 7/13/2021 at 10:40 a.m. Resident 53 was observed in bed in supine position with the head of the bed at 90 degrees and with pillows under his calves to elevate his feet off the bed. Resident 53 stated, I was not repositioned today. I was washed but I am in the same position now as I was at 7 a.m. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/13/2021 at 10:56 a.m. Licensed Vocational Nurse (LVN 2) stated, the resident is at risk for developing pressure ulcers due to risk factors such as immobility, contractures, incontinence, and muscle weakness and should be turned every 2. LVN 2 stated It was the Certified Nursing Assistants (CNA) responsibility to turn Resident 53 every two hours. During an interview on 7/13/2021 at 11:26 a.m., LVN 4 stated This Resident (Resident 53) is not able to move on his own. He is at risk for pressure ulcers. We are supposed to turn and reposition him every 2 hours. I don't see the CNA's turn him every two hours, I'm not going to lie, I see him in the same position for 3 to 4 hours at times but not the whole shift. Since he is a high risk for developing pressure ulcers, he may eventually develop pressure sores. During a review of the facility's policy and procedure (P/P) titled, Pressure Injury Prevention, and revised 8/12/2016, the P/P indicated the Nursing staff will implement interventions identified in the Care Plan based on the individual risk factors which may include but are not limited to repositioning and turning.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36926 Based on observation, interview, and record review, the facility failed to administer oxygen as indicated by the physician for one of one residents (Resident 68), and provide emergency equipment at the bedside for one of one residents (Resident 88) who had a tracheostomy tube (a curved tube that is inserted into a hole made in the neck and windpipe/trachea for breathing). a. Resident 68 had an order for 3 Liters (L) of oxygen, however, the Resident's oxygen was set on 4 L. b. Resident 88 had a tracheostomy tube and the facility did not provide an emergency obturator (used to insert a tracheostomy tube) at the resident's bedside. These deficient practices had the potential for Resident 88 to suffer serious harm or death and Resident 68 to have trouble breathing and damage to the lungs. Findings: a. During a review of Resident 68's Admission Record (Face Sheet), the face sheet indicated Resident 68 was admitted to the facility on [DATE]. Resident 68's diagnoses included acute pulmonary edema (fluid in the lungs), and pulmonary embolism (blood clot in the lungs). During a review of Resident 68's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/29/2021, the MDS indicated Resident 68's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was intact. The MDS indicated Resident 68 required limited assistance with bed mobility, dressing, toileting, and bathing. According to the MDS, Resident 68 was receiving oxygen therapy. During a review of Resident 68's physician's order, dated 7/5/2021, the order indicated to administer oxygen at 3 Liters. During a review of Resident 68's care plan, dated 7/5/2021, the care plan indicated to administer oxygen as ordered. During a concurrent observation and interview on 7/6/2021 at 9:10 a.m., Resident 68 was sitting on the side of the bed, receiving oxygen via nasal canula (a tube that delivers oxygen from a machine to the nose). The oxygen machine was set at 4 L. Resident 68 stated he was supposed to be receiving 3 L of oxygen continuously. During a concurrent observation and interview on 7/6/2021 at 9:14 a.m. Licensed Vocational Nurse (LVN 1) stated per the physician's order, Resident 68's oxygen should be set on 3L. LVN 1 observed Resident 68's oxygen machine and stated, Oh, it is set at 4L, it should be 3L. and proceeded to turn down the oxygen machine to 3 L. 41489 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 88's admission record, the admission record indicated Resident 88 was admitted to the facility on [DATE]. Resident 88's diagnoses included Parkinson's disease (progressive disease of nervous system marked by tremors, muscle stiffness and slow imprecise movement), respiratory failure (condition in which blood does not have enough oxygen or too much carbon dioxide) muscle weakness, and hypertension (high blood pressure). During a review of Resident 88's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 5/7/2021, the MDS indicated Resident 88 had severe cognitive (thought) impairment and is rarely/never understood. The MDS also indicated Resident 88 had trouble breathing when lying flat. During a review of Resident 88's care plan dated 7/2/2021 and titled, Alteration in Respiratory Function, the care plan indicated Resident 88 was at risk for tracheal (airway between the voice box and the lungs) tube obstruction and disconnection. The care plan also indicated to observe and maintain a patent airway. During an observation on 7/06/2021 at 9:40 a.m., Resident 88 was observed in bed and connected to a ventilator (machine that mechanically moves breathable air into and out of the lungs) which supplied oxygen to her via tracheal tube (a tube inserted into the airway to ensure an open passageway to deliver oxygen to the lungs). Further observation indicated there was no emergency tracheal kit (kit that contains a spare cannula [tracheal tube]) with obturator (curved piece of plastic used to help placing the tube in the airway) in Resident 88's room for use in case the tracheal tube was dislodged and Resident 88 could have difficulty breathing. During a concurrent observation and interview on 7/6/2021 at 9:43 a.m., Respiratory Therapist (RT 2) acknowledged there was no emergency tracheal care kit in Resident 88's room. RT 2 stated the emergency tracheal care kit should always be at the resident's bedside. During an interview on 7/12/2021 at 10:16 a.m., RT 2 stated on 7/6/2021 Resident 88 did not have an emergency trach care kit in her room and they placed a tracheal care kit in her room. RT 2 stated all residents with tracheal tubes were supposed to have an emergency tracheal kit in the room. RT 2 stated when residents who require tracheal tubes are admitted they are supposed to have the kit placed in their room. There is a checklist to make sure there is an emergency kit at bedside and should be located at the resident's bedside. The checklist includes the name and recent date of when trach was changed, and verification of an emergency tracheal kit present at the resident's bedside. During a review of Resident 88's tracheostomy daily notes log, dated 7/6/2021 and timed at 6 a.m., the log indicated a spare tracheal tube was at Resident 88's bedside. The log was initialed by RT 2. During an interview on 7/12/2021 at 10:16 a.m., RT 2 stated I signed the checklist because I thought I saw the emergency tracheal kit at bedside, but I was mistaken. During a review of the facility's policy and procedure (P/P), titled, Oxygen Therapy, dated 11/2017, the P/P indicated licensed nursing staff would administer oxygen as prescribed. (continued on next page)

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F 0695 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 Tracheostomy Care, an revised on 7/30/2020, the P/P indicated staff should validate the emergency replacement tracheostomy tubes are available at residents bedside. The policy indicated one tracheostomy tube the same size and type the resident is using and a tracheostomy tube one size smaller than what the resident is using should be present at resident's bedside.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36926 Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater as evidenced by the identification of 3 out of 28 medication opportunities for error, to yield a cumulative error rate of 10.71% for one of three sampled residents (Residents 61), during the medication administration facility task by: 1). Not administering the correct dose of oyster shell calcium with vitamin D 2). Not clarifying the dosage before administering Diclofenac Sodium 1% gel (arthritis pain reliever) These deficient practices had the potential to result in harm to Residents 61 Findings: During a review of Resident 61's Admission Record (Face Sheet), the face sheet indicated Resident 61 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included epilepsy (a neurological disorder causing seizures or periods of unusual behavior and sensations), bipolar disorder (a brain disorder that causes unusual shifts in mood, energy, activity levels), and Parkinson's disease (a disorder of the brain that leads to shaking [tremors] and difficulty with walking, movement, and coordination). During a review of Resident 61's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/21/2021, the MDS indicated Resident 61's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was intact. The MDS indicated Resident 61 required limited assistance with bed mobility, dressing, toileting, and supervision with bathing. During a medication pass observation on 7/7/2021 at 8:15 a.m., Licensed Vocational Nurse (LVN 4), administered one 250 milligram (mg) tablet of Oyster shell calcium plus vitamin D to Resident 61. During a review of Resident 61's physician's order, dated 6/8/2021, the order indicated one tablet of oyster shell 500mg-200IU (vitamin D) twice a day for supplement. During a medication pass observation on 7/7/2021 at 8:15 a.m., Licensed Vocational Nurse (LVN 4), opened the tube of Diclofenac sodium 1% gel and measured 2 Grams (G) of gel onto a dosing card that had marks indicating 2G or 4G and proceeded to apply the medications to Resident 61's right hip and right knee. During a record review of Resident 61's physician's order, dated 5/7/2021, the order indicated Diclofenac sodium 1% (medication for arthritis pain) to right hip and right knee three times a day. The order did not contain a dosage. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 7/8/2021 at 10:45 a.m. LVN 4 stated she gave the 250 mg oyster shell tablet and Vitamin D because the 500 mg bottle did not have vitamin D. LVN 4 stated she should have checked with the pharmacist before giving the tablet and then proceeded to call the facility's consultant Pharmacist (Pharm D 1) on the telephone. Pharm D 1 stated when an order had 200 IU, it was assumed it was vitamin D. Pharm D stated if the facility did not have 500 mg tablets with 200 IU, then it was acceptable to give two 250 mg tablets of oyster shell calcium with vitamin D to equal the 500 mg dosage. However, Pharm D stated the order should be clarified with the physician before making the change to 250 mg tablets. During a review of Resident 61's Medication Administration Records (MARs), dated May 2021. June 2021, and July 2021, the MARs indicated facility staff applied Diclofenac sodium 1% cream to Resident 61 every day from 5/8/2021 - 7/7/2021, however, the MARs did not indicate a dosage for the diclofenac sodium 1% . During a concurrent record review and interview on 7/8/2021 at 10:56 a.m. with LVN 4, when asked how did she know how much (dosage) of diclofenac sodium 1% topical gel to apply to Resident 61, LVN 4 stated she assumed it was 2G because that was what was written on the pharmacy product box label. LVN 4 stated, I just looked at the label on the box, I shouldn't have done that, I should have clarified with the doctor since the dosage was not on the order. Then, LVN 4 called the facility consultant pharmacist (Pharm D 1) on the telephone. Pharm D 1 stated that usually the pharmacy will call the facility and verify with the nurse if there is not a dosage on an order. Pharm D 1stated the pharmacy called the facility on 5/27/2021 and verified with a nurse that the dosage was 2G and stated that was when the medication was dispensed. Pharm D 1 stated she did not know what was being given from 5/7/2021 - 5/27/2021. LVN 4 looked through Resident 61's medical record and was not able to locate any documentation that the order had been clarified with Resident 61's physician. LVN 4 stated, I will call her now and clarify the dosage. During an interview on 7/12/2021 at 2:17 p.m., the Director of Nursing (DON) stated when a resident was admitted to the facility, the admission nurses checks the orders and the pharmacist checks the orders once a month. The DON stated there was no specific process for checking the orders with the MARs on a 24 hours basis or weekly basis unless it was a new admission. During a review of the facility's policy and procedure (P/P), titled, Medication-Administration, dated 1/1/2012, the P/P indicated nursing staff would keep in mind the seven rights of medication when administering medication which included the right medication and right amount. During a review of the facility's policy and procedure (P/P), titled, Physician Orders, dated 8/21/2020, the P/P indicated the facility would have a process to verify that all physician orders were complete and accurate. The P/P indicated the licensed nurse would confirm that physician orders were clear, complete, accurate, and the orders would include the medication dosage. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P), titled, Monthly Review of Physician Orders, dated 1/1/2012, the P/P indicated orders would be reviewed once a month and the purpose of the policy was to ensure the accuracy of physician orders. The P/P indicated the Director of Nursing services or designee would review physician orders and compare the orders to the previous month's records for any discrepancies and orders would be clarified.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43525 Based on observation, interview, and record review, the facility failed to ensure kitchen staffs were routinely trained, monitored and evaluated for competency related to their duties when: 1. Diet Aide 1 (DA 1) and Diet aide 2 (DA 2) stored personal belonging inside the kitchen and unfamiliar with department requirement regarding personal belonging storage. (cross reference F812) 2. DA 2 did not know the difference between regular dessert and controlled carbohydrate (CCHO) diet dessert for 7/6/21 lunch service and served regular desserts to the CCHO diet residents. (cross reference F803) 3. Cook 2 did not know how to calibrate manual thermometer and there was no documented training in-service or documented competency skills evaluation for cooks and diet aides. These failures had the potential to result in unsanitary food storage, inaccurate temperature readings and altered nutrition status for 16 out of 94 residents who received CCHO diets from the kitchen. Findings: 1. During a concurrent observation and interview with the DA 1 on 7/6/21 at 8:20 a.m., there was a bottle of Brisk juice drink inside the reach in freezer. DA 1 stated the bottle belonged to him. DA 1 stated they could store personal item inside the kitchen refrigerator or freezer if it was properly labeled. During an interview with the Dietary Service Supervisor (DSS) on 7/6/21 at 8:24 a.m., DSS stated kitchen staff was not supposed to store personal item in the kitchen refrigerator or freezer. There was a designated employee refrigerator in the employee lounge. During an observation on 7/7/21 at 8:30 a.m., observed one personal portable speaker hanging on the drying rack by the hand washing sink. During an interview with the DSS on 7/7/21 at 8:40 a.m., DSS stated the speaker should not be placed in the kitchen area. During an interview with the diet aide 2 (DA2) at 9:34 a.m., DA 2 stated he left the speaker on the drying rack when he was washing his hand. He moved the speaker inside the janitor closet after he washed his hand. DA 2 state he used janitor closet to store his personal belonging, he always hung his coat and backpack there. 2. During a tray-line observation on 7/6/21 at 11:55 a.m., observed both regular and CCHO diets were served the same size cakes. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's lunch meal spreadsheet (food portioning and serving guide) indicated lunch dessert was fruit mix crumble cake, and CCHO diet should receive 1/2 of regular serving cake. During an interview with the DA 2who served the desserts and side items during tray-line at 7/6/21 at 12:00 p. m., DA 2 stated there was no difference in the desserts today. DA 2 stated both regular and CCHO diets received the same cake with the same size. During an interview with the DSS on 7/6/21 at 12:22 p.m., DSS stated fruit mix crumble cake should have been cut in half for CCHO diets. DSS stated cooks made the desserts but diet aides cut desserts, and portions indicated on the spreadsheet should be followed (Cross reference 803). 3. During a concurrent thermometer calibration observation and interview with the Cook 2 on 7/7/21 at 11:45a.m., Cook 2 stated the temperature should read 32 degree on the thermometer and if thermometer did not reach 32 degree, she would use another thermometer that works. When asked Cook 2 to calibrate the manual thermometer when temperature was not reading 32 degree in the ice bath, Cook 2 stated she did not know how to calibrate it. Cook 2 stated they used digital thermometers in the past, but when thermometers were changed to the manual type, Cook 2 stated there was no training on how to calibrate the manual thermometer. During an interview with the DSS on 7/7/21 at 11:50 a.m. regarding cooks and diet aides in-service training and competency evaluation, DSS stated there were no training records pertaining to thermometer calibration. DSS also stated the previous supervisor did not complete staff competency evaluation for cooks and diet aides. During a review of facility's policy titled calibrating a thermometer, dated 7/1/14, indicated ff the thermometer does not read 32-degree Fahrenheit (F - unit of measurement), leave it in the ice water. Using pliers or an adjustable wrench, turn the adjustable nut located on the back of the thermometer dial until the needle reads 32 degree.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43525 Based on observation, interview, and record review, the facility failed to ensure dessert portion served to controlled carbohydrate diet (CCHO - diet for blood sugar control) were prepared according to the spreadsheet (food portioning and serving guide) instruction on 7/6/2021 lunch service. This failure could result in increased blood sugar levels for 16 out of 94 residents who were on a CCHO diet. Findings: During a tray-line observation on 7/6/2021 at 11:55 a.m., observed both regular and CCHO diets were served the same size cakes. During a review of the facility's lunch meal spreadsheet (food portioning and serving guide), the spreadsheet indicated lunch dessert was fruit mix crumble cake, and CCHO diet should receive 1/2 of regular serving cake. During an interview 7/6/2021 at 12 p.m., the Dietary Aide 2 (DA 2), who served the desserts and side items during tray-line on 7/6/2021 at 11:57 a.m., stated there was no difference in the desserts today. DA 2 stated both regular and CCHO diets received the same cake with the same size. During an interview with the DSS on 7/6/21 at 12:22 p.m., DSS stated fruit mix crumble cake should have been cut in half for CCHO diets. DSS stated cooks made the desserts but diet aides cut desserts, and portions indicated on the spreadsheet should be followed. During a review of facility's policy and procedure (P/P) titled, Therapeutic Diets, dated 6/1/2014, the P/P indicated the dietary manager and dietitian will observe meal preparation and serving to ensure food portions served are equal to the written portion sizes.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43525 Based on observations, interviews and records review, the facility failed to ensure one out of 13 residents (Resident 23) received salad texture prepared according to the mechanical soft diet (food textures modified for people who have difficulty chewing and swallowing) spreadsheet. This failure had the potential to result in decreased intake related to difficulty chewing and increased choking risk for Resident 23. Findings: During a dining observation on 7/6/2021 at 12 p.m., observed Resident 23 had a plate of Caesar salad with croutons on the tray. The meal ticket on Resident 23 plate indicated Resident 23 diet was a mechanical soft diet. During a review of Resident 23 care plan titled, Nutrition, dated 2/21/2020, the care plan indicated Resident 23 was on a mechanical soft diet and Resident 23 was edentulous (without teeth). During a review of facility's lunch spreadsheet, dated 7/6/2021, the spreadsheet indicated for mechanical soft diet to provide 1/2 inch chop Caesar salad with no croutons. During an interview on 7/6/2021 at 12:01 p.m., Licensed Vocational Nurse 2 (LVN 2) stated he checked lunch trays and stated mechanical soft diet should not get croutons. During an interview on 7/6/2021 at 12:03 p.m., the Registered Dietitian (RD) stated mechanical soft diet should not have croutons in the salad. The RD stated the salad served had bigger than 1/2 pieces. During an interview on 7/7/2021 at 11:06 a.m., the RD stated if Resident 23 received and consumed texture not appropriate for the mechanical soft diet, there would be an increased risk of choking and aspiration. During a review of facility's policy and procedure titled, therapeutic diets, dated 6/1/2014, the policy indicated the dietary manager and Dietitian would observe meal preparation and serving to ensure food portions served are equal to the written portion sizes.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observation, interview and record review, the facility failed to ensure fortified cereal was provided as ordered by the physician to one of 13 sampled residents (Resident 14). This failure had the potential to result in decreased caloric intakes and lead to undesirable weight loss. Findings: During a review of resident 14's Admission Record (Face Sheet), the face sheet indicated Resident 14 was admitted to the facility on [DATE]. Resident 14 diagnoses included anorexia (lack or loss of appetite for food) and generalized muscle weakness. During a review of Resident 14's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 5/28/2021, the MDS indicted Resident 14 was moderately impaired of cognition (thought process) for daily decision making. During an interview on 7/8/2021 at 7:40 a.m., Resident 14 stated she only had milk this morning. Resident 14 stated she did not eat foods because they were not good and stated she did not eat hot cereal because they did not have it. During an observation on 7/8/2021 at 7:45 a.m. on Resident 14's tray outside of the room in the enclosed meal cart, the tray had one glass of juice that was still full, one plate of pureed food that were uneaten and one empty carton of milk. There was no cereal bowl on the tray. During a review of Resident 14's physician orders, dated on 11/20/2020, the orders indicated to provide fortified cereal, regular puree texture, thin liquid. During an interview on 7/8/21 at 7:47 a.m., Certified Nursing Assistant 1 (CNA 1) stated when she picked up Resident 14 breakfast tray, Resident 14 only had milk and refused to have any meal alternatives. CNA 1 stated she did not see a cereal bowl on the tray. During an interview on 7/8/2021 at 7:52 a.m., the Dietary Service Supervisor (DSS) stated they made fortified hot cereal in the morning, but she did not know how it was missed on Resident 14 breakfast tray. During an interview on 7/8/21 at 7:58 a.m., the Licensed Vocational Nurse 2 (LVN 2) stated he checked the trays before meal trays were passed to the residents. LVN 2 stated he did not see a cereal bowl on Resident 14 tray when he checked trays this morning and he did not know it was ordered. LVN 2 stated fortified hot cereal was written on the food preference section of the tray ticket, which might have been covered by the food when he was checking the tray and missed it. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy titled, fortified diet, dated 2020, indicated the fortified diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status. The sample fortified meal plan for breakfast included high calorie cereal. During a review of facility's policy and procedure titled, therapeutic diets, dated 6/1/2014, the policy indicated the dietary manager and Dietitian would observe meal preparation and serving to ensure food portions served are equal to the written portion sizes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43525 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Juice machine tubing connectors were disconnected from the machine and left on the shelving with juice dripping, two gnats were flying around the dirty shelf. One juice tubing connector was down inside the dirty floor drain. 2. Not all foods were dated upon receipt, sealed after opened, labeled to identify prepared food content, and discarded prior to use by date. 3. Personal drink stored inside the reach in freezer and personal portable speaker was hanging on the drying rack by the hand washing sink. 4. Food preparation and storage area were not maintained clean. Gap between reach in freezer and food preparation counter had visible dust and food-like debris buildup in between. Shelving inside reach in freezer was dirty and had ice buildup. Floor in the dry storage area was dirty. 5. Cooked beef patty left over from 7/5/21 in the walk-in refrigerator was not monitored for safe cool down process (hot food cooled down within a certain time frame to prevent harmful bacterial growth). 6. Cook 2 did not wash hand after removing gloves, touched lid of the trash bin to discard glove and went back to food preparation. 7. Cook 2 did not follow cleaning and sanitizing procedure after preparing pureed rice on the food preparation counter and the Quaternary ammonium sanitizer used for wiping the counter was below 200 parts per million (PPM - unit of measurement). These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness for 57 out of 94 medically compromised residents who received food from the kitchen. Findings: 1. During a kitchen tour observation on 7/6/2021 at 8:17 a.m., observed juice machine tubing connectors were disconnect from the juice machine and stored on the shelving with juice dripped on the shelf. There were two gnats flying in the shelf where juice was dripped. One of the tubing connectors was inside the dirty floor drain directly under the juice machine shelf. During an interview on 7/6/2021 at 8:27 a.m., the Dietary Service Supervisor (DSS) stated the juice machine was disconnected and not in use. The DSS stated it was scheduled to be picked up by the juice machine company last week, but they didn't come. The DSS stated and confirmed the juice spilled from the tubing could attract pests such as gnats. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a kitchen tour observation on 7/6/2021 at 8:17 a.m., there was one cereal container labeled Rice Krispies with lid opened and another cereal container labeled Cornflakes had a written used by date of 6/30/2021. Three bags of frozen carrots were observed inside the reach in freezer without a received or a used by date. One box of frozen cheese with a used by date of 7/3/2021 and one box of frozen raw chicken with a used by date of 7/5/2021. During an interview on 7/6/2021 at 8:25 a.m., the DSS stated every item delivered should have a received date and an opened date once foods were opened. The DSS stated she could not find the received date on the frozen carrots and the foods that past written used by date should be discarded. During a concurrent observation and interview on 7/6/2021 at 8:34 a.m., the DSS confirmed and stated there were three boxes of strawberries, one bag of grape, one container of watermelons and melons piled together, one container of lettuce without received or a use by date inside the walk-in refrigerator. The DSS stated they should be dated when received. During a concurrent observation of the walk-in refrigerator and interview on 7/6/2021 at 8:37 a.m. the DSS confirmed and stated there was one pitcher labeled NT juice with a written use by date of 7/2/2021. DSS stated nectar thick juice (juice thickened to a nectar like consistency) should be discarded, they should only keep it for three days. Observed one tray of beverage, cups of yogurt-like food labeled as breakfast extra,. The tray was dirty with juice like spills and sticky markings that were left from the tray labels. One tray of sandwich labeled as 8pm snack and unable to identify what type of sandwich it was. The DSS stated food should be labeled to identify its content. During an observation of the walking refrigerator on 7/6/2021 at 8:43 a.m. in the walk in refrigerator, observed one bottle of lemon juice past use by date of 6/30/2021, one pitcher labeled as caramel with a used by date of 6/13/2021, one bag of tortilla with received date of 5/11/2021 and another bag with 4/26/2021 and one bag of hot dog buns without receive or a use by date. During an observation of the walking refrigerator on 7/6/2021 at 8:48 a.m., observed one box of potatoes, onions, and banana stored under kitchen counter did not have receive or use by date. There were six sprouted potatoes and bananas were very ripe with a lot of dark spots. During an observation of the walking refrigerator on 7/6/2021 at 9:03 a.m. inside the dry food storage area, observed one bag of opened Rice krispies with used by date of 7/2/2021. Six canned apricots without a received date. One bag of opened pasta without an opened date or use by date. One box of dry powder crystal and four boxes of thickened water did not have received dates. During an interview on 7/6/2021 at 9:04 a.m. regarding food storage area dating and monitoring system, the DSS stated she would check dating and labeling, but cooks should also be checking daily. During a review of facility's policy and procedure titled, Receiving food and Supplies, dated 11/1/2014, the policy indicated Items received should be dated with FIFO (first in first out) rotation and Food stock should be rotated with each new order received. 3. During a concurrent observation and interview on 7/6/2021 at 8:20 a.m., with the diet aide (DA 1), there was a bottle of Brisk juice drink inside the reach in freezer. The DA 1 stated the bottle belonged to him. The DA 1 stated they could store personal item inside the kitchen refrigerator or freezer if it was properly labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/6/2021 at 8:24 a.m., DSS stated kitchen staff was not supposed to store personal item in the kitchen refrigerator or freezer. There was a designated employee refrigerator in the employee lounge. During an observation on 7/7/2021 at 8:30 a.m., observed one personal portable speaker hanging on the drying rack by the hand washing sink. During an interview with the DSS on 7/7/21 at 8:40 a.m., the DSS stated the speaker should not be placed in the kitchen area. During an interview on 7/7/2021 at 9:34 a.m., DA 2 stated he left the speaker on the drying rack when he was washing his hand. He moved the speaker inside the janitor closet after he washed his hand. DA 2 state he used janitor closet to store his personal belonging, he always hung his coat and backpack there. 4. During a concurrent kitchen tour observation on 7/6/21 at 8:29a.m., the DSS stated and confirmed there was a gap between the reach in freezer and the food preparation counter with visit dusts and cereal-like crumbs stuck in between the gap. The single door reach in freezer inside the storeroom had ice buildup on the bottom shelf. There were orange color spills at the bottom shelf. The floor inside dry storage area near storage shelf has visible [NAME] build up at the corner, there were oatmeal and cereal crumbs on the floor. The DSS stated and confirmed the floor was dirty and stated floor should have been cleaned daily. DSS stated the current cleaning log did not include freezer shelf cleaning and it should've been added. During a review of facility's policy and procedure titled, cleaning schedule, dated 10/1/2014, the policy indicated the dietary staff would maintain a sanitary environment in the Dietary department by complying with the routine cleaning schedule developed by the Dietary Manager and the dietary manager monitors the cleaning schedule to ensure compliance. 5. During a concurrent observation and interview on 7/6/2021 at 8:37 a.m. in the presence of the DSS inside the walk-in refrigerator, there was one container of cooked diced chicken dated 7/5/2021 with a used by date of 7/10/21, and one container of cooked beef patty dated 7/5/2021 with a used by date of 7/7/2021. The DSS stated typically they do not save left over foods, but if any leftover was saved, it would need to be monitored for safe cooling on the cool down log. The DSS stated there is no documentation on the cooling log for 7/5/2021. During an interview on 7/6/2021 at 9:17 a.m., Cook 1 stated he did not monitor beef patty left over for safe cooling. He stated he could not find the cool down log on 7/5/2021 so he did not do it. During a review of facility's policy and procedure titled, leftovers, dated 7/1/2014, the policy indicated dietary department employees would use safe food handling rules with the use and storage of leftover food. The procedure indicated to remove food from holding area after meal service is complete, chill uncovered foods to 41-degree Fahrenheit (F - unit of measurement) or lower according to policy DS-23-Hazardous Foods Cooling Monitor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, hazardous foods cooling monitor, dated 7/1/2014, the policy indicated dietary department employee will follow food handling rules for hazardous foods, and hazardous foods are defined as: soy protein/meats/fish, chicken/turkey/shellfish. 6. During a food preparation observation on 7/7/2021 at 9:50 a.m., observed Cook 2 removed gloves after pureeing rice and removed trash bin lid with her bare hand to discard the gloves. Cook 2 then went back to putting foil on pureed rice and placed it inside the oven. Cook 2 also went into the walk-in refrigerator, brought two pans out and place the pans inside the oven. Cook 2 did not wash her hands after removing gloves and touching trash bin lids. During an interview on 7/7/2021 at 9:51 a.m., Cook 2 stated she removed gloves because it was dirty. Cook 2 stated she forgot she should have washed hands before resuming food preparation. During a review of the facility's policy and procedure titled, dietary department - infection control for dietary employees, dated 11/9/2016, indicated proper handwashing by personnel will be done during food preparation, as often as necessary to remove soil and contamination and to prevent cross- contamination when changing tasks. 7. During a food preparation observation on 7/7/2021 at 10 a.m., observed Cook 2 took the towel from the sanitizer red bucket to wipe down the counter, removing left over rice on the counter after preparing pureed rice. Cook 2 placed the used towel back into the sanitizer bucket and proceed to taking baked chicken out from the oven and placed the baked chicken on the counter. During an interview on 7/7/2021 at 10:02 a.m. regarding cleaning and sanitizing procedure, the DSS stated if the counter was soiled with food particles, it should be cleaned with detergent first, then sanitize with a sanitizer. During a concurrent sanitizer concentration check with the DSS on 7/7/2021 at 10:05 a.m., the DSS checked the sanitizer from the bucket that Cook 2 used to wipe down the counter, the color appeared light green on the test strip. When DSS compared the test strip color to the concentration indicator on the test strip label, DSS stated it's between 100-200 ppm. The DSS stated it should be 200 ppm when asked what the correct concentration should be for effective sanitization when using the quaternary ammonium sanitizer. During a review of facility's log titled, red bucket sanitizer log, revised 10/2014, the log indicated if sanitizer wa not in the appropriate range, do not use to sanitize. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Juice machine tubing connectors were disconnected from the machine and left on the shelving with juice dripping, two gnats were flying around the dirty shelf. One juice tubing connector was down inside the dirty floor drain. 2. Not all foods were dated upon receipt, sealed after opened, labeled to identify prepared food content, and discarded prior to use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Personal drink stored inside the reach in freezer and personal portable speaker was hanging on the drying rack by the hand washing sink. 4. Food preparation and storage area were not maintained clean. Gap between reach in freezer and food preparation counter had visible dust and food-like debris buildup in between. Shelving inside reach in freezer was dirty and had ice buildup. Floor in the dry storage area was dirty. 5. Cooked beef patty left over from 7/5/21 in the walk-in refrigerator was not monitored for safe cool down process (hot food cooled down within a certain time frame to prevent harmful bacterial growth). 6. Cook 2 did not wash hand after removing gloves, touched lid of the trash bin to discard glove and went back to food preparation. 7. Cook 2 did not follow cleaning and sanitizing procedure after preparing pureed rice on the food preparation counter and the Quaternary ammonium sanitizer used for wiping the counter was below 200 parts per million (PPM - unit of measurement). These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness for 57 out of 94 medically compromised residents who received food from the kitchen. FINDINGS: 1. During a kitchen tour observation on 7/6/21 at 8:17 a.m., observed juice machine tubing connectors were disconnect from the juice machine and stored on the shelving with juice dripped on the shelf. There were two gnats flying in the shelf where juice was dripped. One of the tubing connectors was inside the dirty floor drain directly under the juice machine shelf. During an interview with the dietary service supervisor (DSS) on 7/6/21 at 8:27 a.m., DSS stated the juice machine was disconnected and not in use. DSS stated it was scheduled to be picked up by the juice machine company last week, but they didn't come. DSS stated she agreed the juice spilled from the tubing could attract pests such as gnats. 2. During a kitchen tour observation on 7/6/21 at 8:17 a.m., there was one cereal container labeled Rice Krispies with lid opened and another cereal container labeled Cornflakes had a written used by date of 6/30/21. On 7/6/21 at 8:21 a.m., observed three bags of frozen carrots inside the reach in freezer without a received or a used by date. One box of frozen cheese with an used by date of 7/3/21 and one box of frozen raw chicken with an used by date of 7/5/21. During an interview with the DSS on 7/6/12 at 8:25 a.m., DSS stated every item that were delivered should have a received date and an opened date once foods were opened. DSS stated she could not find the received date on the frozen carrots and the foods that past written used by date should be discarded. (continued on next page)

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	055077	A. Building B. Wing	07/13/2021

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Coral Cove Post Acute	1730 Grand Ave Long Beach, CA 90804

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with the DSS on 7/6/21 at 8:34 a.m., there were three boxes of strawberries, one bag of grape, one container of watermelons and melons piled together, one container of lettuce without received or a use by date inside the walk-in refrigerator. DSS stated they should be dated when received. During a concurrent observation and interview with the DSS on 7/6/21 at 8:37 a.m. inside the walk-in refrigerator, there was one pitcher labeled NT juice with a written use by date of 7/2/21. DSS stated nectar thick juice (juice thickened to a nectar like consistency) should be discarded, they should only keep it for three days. During a concurrent observation and interview with the DSS on 7/6/21 at 8:37 a.m. inside the walk-in refrigerator, observed one tray of beverage, cups of yogurt-like food labeled as breakfast extra. The tray was dirty with juice like spills and sticky markings that were left from the tray labels. One tray of sandwich labeled as 8pm snack and unable to identify what type of sandwich it was. DSS stated food should be labeled to identify its content. On 7/6/21 at 8:43 a.m. in the walk in refrigerator, observed one bottle of lemon juice past use by date of 6/30/21, one pitcher labeled as caramel with a used by date of 6/13/21, one bag of tortilla with received date of 5/11/21 and another bag with 4/26/21 and one bag of hot dog buns without receive or a use by date. on 7/6/21 at 8:48 a.m., observed one box of potatoes, onions, and banana stored under kitchen counter did not have receive or use by date. There were six sprouted potatoes and bananas were very ripe with a lot of dark spots. On 7/6/21 at 9:03 a.m. inside the dry food storage area, observed one bag of opened Rice krispies with used by date of 7/2/21. Six canned apricots without a received date. One bag of opened pasta without an opened date or use by date. One box of dry powder crystal and four boxes of thickened water did not have received dates. During an interview with the DSS on 7/6/21 at 9:04 a.m. regarding food storage area dating and monitoring system, DSS stated she would check dating and labeling, but cooks should also be checking daily. A review of facility's policy and procedure titled receiving food and supplies, dated 11/1/14, indicated Items received should be dated with FIFO (first in first out) rotation, and Food stock should be rotated with each new order received. 3. During a concurrent observation and interview with the diet aide (DA 1) on 7/6/21 at 8:20 a.m., there was a bottle of Brisk juice drink inside the reach in freezer. DA 1 stated the bottle belonged to him. DA 1 stated they could store personal item inside the kitchen refrigerator or freezer if it was properly labeled. During an interview with the DSS on 7/6/21 at 8:24 a.m., DSS stated kitchen staff was not supposed to store personal item in the kitchen refrigerator or freezer. There was a designated employee refrigerator in the employee lounge. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/7/21 at 8:30 a.m., observed one personal portable speaker hanging on the drying rack by the hand washing sink. During an interview with the DSS on 7/7/21 at 8:40 a.m., DSS stated the speaker should not be placed in the kitchen area. During an interview with the diet aide 2 (DA2) at 9:34 a.m., DA 2 stated he left the speaker on the drying rack when he was washing his hand. He moved the speaker inside the janitor closet after he washed his hand. DA 2 state he used janitor closet to store his personal belonging, he always hung his coat and backpack there. 4. During a concurrent kitchen tour observation with DSS on 7/6/21 at 8: 29a.m., there was a gap between the reach in freezer and the food preparation counter with visit dusts and cereal-like crumbs stuck in between the gap. On 7/6/21 at 8:32 a.m., the single door reach in freezer inside the storeroom had ice build up on the bottom shelf. There were orange color spills at the bottom shelf. On 7/6/21 at 9:05 a.m., the floor inside dry storage area near storage shelf has visible [NAME] build up at the corner, there were oatmeal and cereal crumbs on the floor. During an interview with the DSS on 7/6/21 at 9:06 a.m., DSS agreed the floor was dirty and stated floor should have been cleaned daily. DSS stated the current cleaning log did not include freezer shelf cleaning and it should've been added. A review of facility's policy and procedure titled cleaning schedule, dated 10/1/14, indicated The dietary staff will maintain a sanitary environment in the Dietary department by complying with the routine cleaning schedule developed by the Dietary Manager, and The dietary manager monitors the cleaning schedule to ensure compliance. 5. During a concurrent observation and interview with the DSS on 7/6/21 at 8:37 a.m. inside the walk-in refrigerator, there was one container of cooked diced chicken dated 7/5/21 with a used by date of 7/10/21, and one container of cooked beef patty dated 7/5/21 with a used by date of 7/7/21. DSS stated typically they do not save left over foods, but if any leftover was saved, it would need to be monitored for safe cooling on the cool down log. When requested to review the cooling log, DSS stated it was not documented on the cooling log on 7/5/21. During an interview with Cook 1 on 7/6/21 at 9:17 a.m., Cook 1 stated he did not monitor beef patty left over for safe cooling. He stated he could not find the cool down log on 7/5/21 so he did not do it. A review of facility's policy and procedure titled leftovers, dated 7/1/14, indicated Dietary department employees will use safe food handling rules with the use and storage of leftover food. The procedure indicated to Remove food from holding area after meal service is complete .Chill uncovered foods to 41-degree Fahrenheit (F - unit of measurement) or lower according to policy DS-23-Hazardous Foods Cooling Monitor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility's policy and procedure titled hazardous foods cooling monitor, dated 7/1/14, indicated Dietary department employee will follow food handling rules for hazardous foods, and Hazardous foods are defined as: . d. soy protein/meats/fish .f. chicken/turkey/shellfish. 6. During a food preparation observation on 7/7/21 at 9:50 a.m., observed Cook 2 removed gloves after pureeing rice and removed trash bin lid with her bare hand to discard the gloves. Cook 2 then went back to putting foil on pureed rice and placed it inside the oven. Cook 2 also went into the walk-in refrigerator, brought two pans out and place the pans inside the oven. Cook 2 did not wash her hands after removing gloves and touching trash bin lids. During an interview with Cook 2 on 7/7/21 at 9:51 a.m., Cook 2 stated she removed gloves because it was dirty. Cook 2 stated she forgot she should have washed hands before resuming food preparation. A review of facility's policy and procedure titled dietary department - infection control for dietary employees, dated 11/9/16, indicated Proper handwashing by personnel will be done as follows: .G. During food preparation, as often as necessary to remove soil and contamination and to prevent cross- contamination when changing tasks. 7. During a food preparation observation on 7/7/21 at 10 a.m., observed Cook 2 took the towel from the sanitizer red bucket to wipe down the counter, removing left over rice on the counter after preparing pureed rice. Cook 2 placed the used towel back into the sanitizer bucket and proceed to taking baked chicken out from the oven and placed the baked chicken on the counter. During an interview with the DSS on 7/7/21 at 10:02 a.m. regarding cleaning and sanitizing procedure, DSS stated if the counter was soiled with food particles, it should be cleaned with detergent first, then sanitize with a sanitizer. During a concurrent sanitizer concentration check with the DSS on 7/7/21 at 10:05 a.m., DSS checked the sanitizer from the bucket that Cook 2 used to wipe down the counter, the color appeared light green on the test strip. When DSS compared the test strip color to the concentration indicator on the test strip label, DSS stated it's between 100-200 ppm. DSS stated it should be 200 ppm when asked what the correct concentration should be for effective sanitization when using the quaternary ammonium sanitizer. A review of facility's log titled red bucket sanitizer log, revised 10/2014, indicated If sanitizer is not in the appropriate range- Do not use to sanitize.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 43525 Based on observation, interview and record review, the facility failed to ensure trash stored in the dumpster area was maintained in a sanitary manner when one out of four garbage dumpsters were overfilled. This failure had the potential to attract disease causing pests to harbor in the dumpster area. Findings: During a concurrent observation and interview on 7/6/2021 at 9:41 a.m., the Dietary Service Supervisor (DSS) acknowledge one garbage dumpster in the parking lot were overfilled with cardboard boxes and both lids were unable to close. The DSS stated trash bin should not be overfilled. During an interview on 7/7/2021 at 8:51 a.m., the Director of Maintenance (DOM) stated the garbage dumpsters were maintained by the housekeeping staff. DOM stated he would do rounds to ensure cleanliness of the area and ensure garbage dumpster lids were closed. However, the DOM stated they may need more dumpsters as trash sometimes cannot all fit before trash collection time. The Facility did not have a policy specific to garbage dumpster maintenance and monitoring. According to the 2017 U.S. Food and Drug Administration Food Code, proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be a possible source of contamination of food, equipment, and utensils. In addition, storage areas must be large enough to accommodate all the containers necessitated by the operation to prevent scattering of the garbage and refuse. All containers must be maintained in good repair and cleaned as necessary to store garbage under sanitary conditions as well as to prevent the breeding of flies.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 39085 Based on observation, interview, and record review, the facility failed to make a good faith effort to permanently repair the broken call light system previously identified as an immediate jeopardy deficiency; using the Quality Assurance and Performance Improvement ([QAPI] the coordinated application of two mutually-reinforcing aspects of a quality management system, taking a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality, while involving residents and families, and all nursing home caregivers in practical, and creative problem solving) by reviewing services, outcomes, and systems throughout the facility for assuring that call lights within the facility worked, in relation to those standards, to decrease the risks associated with residents' not being able to summon help. This deficient practice had the potential for 14 of 94 (5,10, 14, 21, 23, 26, 53, 55, 80, 81, 83, 88, 89,98,) residents' needs being unmet, residents' feeling isolated and neglected due not being able to call for help. Findings: During observations on 7/6/21 and 7/7/21, call lights within rooms 32, 35, 36, 37, 38, 39, and 40 were not working. During a concurrent interview and record review on 7/9/21 at 1:25 p.m., of the facilities QAPI Binder for 2021, containing identified system issues the QAPI team and the facility were working on improving, Director of Nursing (DON) stated the failing call lights had been identified in April 2021 as a system failure. DON stated facility staff check the call lights daily and gives a call bell to the resident if the lights are not working. DON stated the QAPI committee did not implement any other measures to permanently fix the call light system. DON stated the purpose of QAPI was to identify system failures in the facility, such as falls, and pressure ulcers, and implement interventions with a system in place to check for effectiveness. DON stated this directly affects the quality of care and quality of life of the facility's residents. During a review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated 9/19/19 indicated performance improvement projects would be used to examine and improve care and services. Root cause analysis (the process of identifying the underlying reason for a problem, to approach the problem with solutions to prevent re-occurrence) would be used to identify underlying causes in areas needing attention and to develop action plans.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42380 Based on observation, interview, and record review, the facility failed to implement infection control interventions in the yellow zone (unit for residents suspected Corona Virus [COVID-19] a highly contagious virus that causes severe respiratory illness that affects the lungs and airways) to prevent and control the spread of COVID-19 for six (6) of thirteen (13) residents (Residents 1, 2, 3, 4, 5, and 6) and three (3) out of four (4) staff in the facility in accordance with the facility's infection control policies and procedures (P/P) and mitigation plan ([MP] a plan to reduce the spread of the COVID-19 virus) by failing to: 1. Provide and ensure that four of four visitors (Visitor 1, 2, 3 and 4) in the yellow zone are wearing required Personal Protective Equipment (PPE, gowns, gloves, N95 -facemask that filters out a minimum of 95 percent of airborne particles and gloves). 2. Provide education to four of four visitors (Visitor 1, 2, 3 and 4) regarding Covid-19 protocols and PPE requirements in the yellow zone. 3. Ensure two of three staff (CK1 and KA1) were wearing a face mask while preparing food. 4. Ensure one of two unvaccinated staff (KA1) and two of two vaccinated staff (CK1 and SCR1) in the facility were fit tested for N95 respirator. 5. Ensure Certified Nurse Assistant (CNA1) put on face shield and gown prior to entering the residents' room in the yellow zone and providing care to the resident. These deficient practices had the potential to result in the spread of COVID-19 infection to Residents 2 and 4, who were not vaccinated (not inoculated with a vaccine to provide immunity against a disease), vaccinated Residents 1, 3, 5, and 6, staff members, and visitors which can potentially lead to serious respiratory illness, hospitalization , and death to others. On 8/19/2021, at 6:55 p.m., the newly hired Administrator (ADM1), current Administrator (ADM2), Assistant Director of Nursing (ADON), Infection Preventionist (IP) and Registered Nurse Consultant (RNC1), were notified an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident), was called for the facility's staff inability to follow and implement infection protocols to prevent the spread of COVID-19 in the facility. The facility's ADM1, ADM2, ADON, IP and RNC1 were notified of the immediacy and seriousness of other residents' and staff members health and safety being threatened for not adhering to infection control protocols. On 8/21/2021 at 5:32 p.m., the facility submitted an acceptable Plan of Action (POA) and indicated the following actions for the IJ removal: 1. On 8/19/21, Infection Preventionist and Regional Quality Management Consultant (RQMC) made rounds to see if there were any visitors in the yellow zone without proper PPE. None were observed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 8/20/21, the facility receptionist was provided 1:1 education by the RQMC regarding visitation guidance specifically the requirement for facility staff to provide education and supervise the visitor's donning and doffing PPE. PPE is required regardless of vaccination status per the COVID-19 mitigation plan. 3. On 8/19/21, unvaccinated dietary staff were immediately provided N95 mask by the Infection Preventionist to be worn at all times while within the facility. 4. On 8/19/21, all dietary staff were immediately in serviced by Infection Preventionist about wearing appropriate masks at all times while within the facility. 5. On 8/19/21, the staff member in the yellow zone was provided 1:1 education by the Infection Preventionist regarding proper infection control practices and usage of appropriate PPE per the COVID-19 mitigation plan. 6. On 8/19/21, staff present in the facility were in serviced by Infection Preventionist nurse regarding proper infection control practices and usage of appropriate PPE per the COVID-19 mitigation plan while providing care in the yellow zone. 7. On 8/19/21, Infection Preventionist completed rounds to identify other visitors or staff within the facility without proper PPE, there were no other visitors or staff were identified to be in the facility without proper PPE. 8. On 8/19/21 and 8/20/21, the licensed nurses conducted an assessment of 98 residents who were assessed to identify residents who were affected by the deficient practice. No residents were identified to be affected. 9. On 8/20/21, the Infection Preventionist administered a Covid-19 antigen test for the 13 residents in the yellow zone to identify residents who were affected by the deficient practice. No residents were identified to be affected. 10. On 8/19/21, the Regional Quality Management Consultant, Director of Staff Development, and/or the Infection Preventionist provided education to the staff on COVID-19 mitigation plan with emphasis on visitation guidance and proper usage of PPE. Staff who are unscheduled to work or on leave of absence will be provided with education by the DON/Designee upon return to work prior to start of shift. As of 8/21/21, 109 of 139 staff members have been educated. 11. The PM Shift RN Supervisor/Designee will make facility infection control rounds twice a shift to assure the proper use of PPE in the yellow zone. 12. The Night Shift Supervisor/Designee will make facility infection control rounds twice a shift to assure the proper use of PPE in the yellow zone. 13. The Receptionist will screen all visitors upon arrival to the facility and notify the licensed nurse of the visitors' arrival. The licensed nurse will provide the visitors with the appropriate PPE such as N95 mask, provide the visitors education on the proper usage of PPE, and escort the visitors to the unit and provide visitors with the remainder of the required PPE. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	14. On 8/19/21, all unvaccinated staff present in the facility were provided education by the Infection Preventionist nurse about wearing N95 masks when in indoor settings where 1) care is provided to residents, 2) residents have access for any purpose. Staff who are unscheduled to work or on leave of absence will be provided with education by the DON/Designee upon return to work prior to start of shift. As of 8/21/21, 12 out of 14 unvaccinated staff members were provided education. 15. On 8/19/21, all dietary staff present in the facility were provided education by the Infection Preventionist nurse about wearing appropriate masks at all times while within the facility. Staff who are unscheduled to work or on leave of absence will be provided with education by the DON/Designee upon return to work, prior to start of shift. 16. On 8/19/21, staff were provided education by the Infection Preventionist on wearing needed PPE (N95 masks, gowns, face shields and gloves) when entering residents' rooms in the yellow zone. Staff who are unscheduled to work or on leave of absence will be provided with education by the DON/Designee upon return to work, prior to start of shift. 17. On 8/20/21, the receptionist was provided education by the Infection Preventionist and RQMC regarding visitation guidance specifically the requirement for facility staff to provide education and supervise the visitors' donning and doffing of PPE. PPE is required regardless of vaccination status per the COVID-19 mitigation plan. 18. All the visitors will be screened at front entrance door and informed/educated regarding proper PPE use in the yellow zone during visitation. This shall be initiated by the receptionist or designee and documented on Visitation Log for Yellow Zone. 19. The RN supervisor or designee shall monitor visitors' compliance of keeping PPE on during visitation in the yellow zone. If a visitor is found to be non-compliant, they will be encouraged to comply or will be asked to leave the facility. 20. A sign was placed on each room's door in the yellow zone to alert visitor to wear proper PPE prior to entering the patient room. 21. The dietary staff shall be monitored by the Dietary Supervisor or designee twice a shift for use of proper PPE/masks using an Employee PPE log. 22. All staff providing care in the yellow zone shall use proper PPE as per mitigation plan. Infection Preventionist nurse/designee shall conduct infection control compliance rounds to assure proper use of PPE in the yellow zone two times a shift. 23. The Administrator and Director of Nursing will review the monitoring rounds and employee PPE log on a daily basis and present the non-compliance issues to the Quality Assurance and Performance Improvement Committee monthly for further review and interventions for the next 3 months, then quarterly thereafter until substantial compliance is sustained. 24. The Administrator and the Director of Nursing are responsible to ensure sustained compliance. Findings: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. During a concurrent observation and interview with visitor 1 (V1) in the yellow zone on 8/19/2021 at 12:48 p.m., V 1 was observed in the residents' room, cleaning Resident 1's hands. V 1 was not wearing an N95 mask. V 1 stated she was not offered one by the facility and was not made aware that she needed a N95 mask. During a review of Resident 1's Admission Record (Face Sheet), face sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses include chronic respiratory failure (condition where lungs have a hard time loading your blood with oxygen or removing carbon dioxide), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), hemiplegia (paralysis of one side of the body), heart failure (condition where the heart doesn't pump blood as well as it should), diabetes (condition in which body ineffective uses blood sugar) and hypertension (force of blood against artery walls is too high). During a review of Resident 1's Minimum Data Set (MDS) a standardized assessment and care planning tool), dated 8/5/2021, the MDS did not indicated Resident 1's cognition (thought process), but indicated needed total physical assistance with activities of daily living (ADL) such as personal hygiene, toilet use, transferring and getting dressed. During a review of Resident 1's Health and Social History, the record indicated Resident1 received his first dose of COVID-19 vaccine on 2/1/21 and second dose on 3/4/21. 2. During an observation in the yellow zone on 8/19/2021 at 12:57 p.m., Visitor 2 (V2) was observed not wearing an N95 or any kind of facial covering, face shield, gown and gloves while standing in the yellow zone hallway in front of room [ROOM NUMBER]. Certified Nurse Assistant (CNA1) was observed passing V 2 as he was walking out of room [ROOM NUMBER], V 2 proceeded to enter room [ROOM NUMBER] and taking a seat on Resident 2's bed. CNA1 did was not observed to address and/or educate V 2's lack of PPE. There were three residents (Resident 2, 4, and 5) observed residing in room [ROOM NUMBER]. During a review of Resident 2's Admission Record (Face Sheet), face sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses include hypertension (force of blood against artery walls is too high), cerebral ischemia (lack of blood flow to the brain) and encephalopathy (disease that alters brain function or structure). During a review of Resident 2's Minimum Data Set (MDS) a standardized assessment and care planning tool), dated 8/20/2021, the MDS indicated Resident 2 has no cognition (thought process) impairment and required physical assistance with activities of daily living (ADL) such as transferring, personal hygiene, toilet use, eating and getting dressed. During a review of Resident 4's Admission Record (Face Sheet), face sheet indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses include hypertension (force of blood against artery walls is too high), anemia (lack healthy red blood cell to carry adequate oxygen to body tissue), obesity (excessive body fat), and atherosclerosis (buildup of fats, cholesterol, and other substances in and on the artery walls). During a review of Resident 4's Minimum Data Set (MDS) a standardized assessment and care planning tool), dated 8/18/2021, the MDS indicated Resident 4's has no cognition (thought process) impairment and required physical assistance with activities of daily living (ADL) such as personal hygiene, toilet use and getting dressed. (continued on next page)

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	055077	A. Building B. Wing	07/13/2021

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 5's Admission Record (Face Sheet), face sheet indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses include hypertension (force of blood against artery walls is too high), breast cancer (malignant tumor that forms from the uncontrolled growth of abnormal breast cells), atherosclerosis (buildup of fats, cholesterol, and other substances in and on the artery walls) and diabetes (condition in which body ineffective uses blood sugar). During a review of Resident 5's Minimum Data Set (MDS) a standardized assessment and care planning tool), dated 8/18/2021, the MDS indicated Resident 5's has no cognition (thought process) impairment and required physical assistance with activities of daily living (ADL) such as personal hygiene, toilet use and getting dressed. During a review of Resident 5's Immunization History Report, the record indicated Resident 5 received one of one dose of COVID-19 vaccine on 4/8/2021. During an interview on 8/19/2021 at 1:12 p.m. with V 2, V 2 stated, he was not informed that he had to wear a mask or any of the other PPE. V 2 stated, he walked in through facility's front entrance, his temperature was taken, and he walked to room [ROOM NUMBER]. V 2 stated he was not offered any kind of PPE and was not given any education or instructions about what was expected of him, like informing the facility if he had signs and symptoms of COVID-19. During an interview on 8/19/2021 at 1:08 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated anyone in the yellow zone, including visitors, need to comply with PPE requirements such as N95 mask, face shield, gown, and gloves. LVN 3 stated it is the staff's responsibility to educate and provide PPE to visitors when visitation is in the yellow zone. LVN 3 expressed that upon entrance to the residents' rooms, all PPE should be on to prevent the spread of COVID-19 infection. LVN 3 stated that aside for Resident 2 there are two other residents in room [ROOM NUMBER] (Resident 4 and 5) who are put at risk for infection due to Visitor 2's lack of PPE. LVN 3 educated and instructed Visitor 2 to hand sanitize, put on N95, face shield, gowns, and gloves on. During an interview on 8/19/2021 at 2:51 p.m. with the Receptionist (RCP), RCP stated she was responsible for educating visitors on what type of PPE to wear, but she failed to educate V 2. She stated she did not provide V 2 with PPE as well, because she was not aware that the resident Visitor 2 was visiting, was moved to the yellow zone and didn't realize V 2 was heading to the yellow zone. During an interview on 8/19/2021 at 2:16 p.m. with the Infection Preventionist (IP), IP stated the visitors are screened by the receptionist for covid-19 symptoms, temperature checked, rapid tested if not fully vaccinated, educated about reporting to facility if the visitors start to develop symptoms, hand sanitizing, PPE needed during the visitation and what was expected of them during the visit. The IP stated those visiting the yellow zone check in and proceed to meet with yellow zone staff who will provide them with PPE, which includes N95, face shield, gowns, gloves. IP stated she does not know what happened with the observed visitors not wearing PPE's, because the charge nurse was supposed to give them PPE's, monitor donning and doffing and provide more education. The IP emphasized that N95 and PPE are important to be in place to protect residents, staff and visitors from Covid-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's COVID-19 Mitigation Plan (MP) revised on 8/6/2021, the MP indicated visitors will be informed they must notify the facility if they develop respiratory symptoms or test positive for COVID-19 during the period of 14 days following their visit to the facility, the date of their visit, who they were in contact with and locations of the facility they visited. MP further indicated for visits requiring visitors to wear PPE due to the resident being in quarantine or isolation, facility staff will provide education and supervise the visitor's donning and doffing of PPE. PPE is required regardless of vaccination status. MP continues to indicate, Full PPE (gloves, gown, eye protection and N95 respirator) must be worn during visitation in the yellow zone (observation or exposed status). Visitors must be instructed in performing a seal check for N95 respirator. MP also addressed that in yellow area N95 respirator should be worn for duration of the shift and doffed when contaminated, goggles or face shield should be worn when providing care within six feet of a resident. Gowns should be worn and changed between resident encounters. MP further indicated that staff should always wear a surgical/procedure mask (unless N95 respirator is required) for universal source control while they are in the facility. It also indicated that that the unvaccinated worker must wear a surgical mask or higher level of respirator approved by NIOSH at all times while in the facility. During a review of the California Department of Public Health All Facilities Letter (AFL) 20-22.9 (AFL 20-22.9), dated 8/12/2021, indicated visits for residents who share a room should be conducted in a separate indoor space or with the roommate not present in the room (if possible), regardless of roommate's vaccination status. Visitors should be provided personal protective equipment (gloves, gown, eye protection and N95 respirator) and instructed in a N95 respirator seal check for visitation of residents in yellow (exposed or observation status) areas. During a review of the California Department of Public Health All Facilities Letter (AFL) 21-28 (AFL 21-28), dated 8/3/2021, under section 'Additional Personal Protective Equipment and Masking for Unvaccinated HCP' indicated The Aerosol Transmissible Disease (ATD) Standard (Title 8 of the California Code of Regulations section 5199) requires all employees in an area or residence where a suspected or confirmed COVID-19 case is present to use National Institute for Occupational Safety and Health (NIOSH) approved respirators. An N95 is the minimum protection permitted for these employees. AFL21-28 further indicates that facilities must provide respirators to all unvaccinated or workers who work in indoor work settings where (1) care is provided to patients or residents, or (2) to which patients or residents have access for any purpose. During a review of the California Occupational Safety and Health ([Cal/OSHA], a program responsible for enforcing California laws and regulations pertaining to workplace safety and health) guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages dated 8/2020 indicated employers must implement work practices to minimize the number of employees exposed to suspected and confirmed COVID-19 residents. The guidelines also indicated initial respirator fit testing was required before an employee used a respirator, or when an employee changed to a different model, make, or size of respirator. According to the guidelines, annual respirator fit testing was required by all facilities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36926 Based on interview and record review, the facility failed to implement its policy and procedures (P/P) and ensure there was a consistent process for screening and determining eligibility for residents to receive influenza ([flu], a respiratory virus that infects the nose, throat, and lungs; spread when people with flu cough, sneeze or talk, sending droplets with the virus into the air and potentially into the mouths or noses of people who are nearby) and pneumonia (a bacterial, viral, or fungal infection of the lungs that causes the air sacs, or alveoli, of the lungs to fill up with fluid or pus) vaccines, ensure the provision of education related to influenza and pneumococcal vaccines, and ensure administration of pneumococcal and/or influenza vaccines for 4 of 5 residents (Residents 61, 70, 67, 37). This deficient practice had the potential to place Residents 37, 61, 67, 70 and other residents, staff members, visitors, and the community at risk of acquiring, transmitting, and or experiencing complications from an outbreak of influenza and pneumonia. Findings: During a concurrent interview and record review on 7/8/2021 at 12:26 p.m. the Infection Preventionist (IP) stated they usually try to offer the flu vaccine (during flu season, October 1st- March 31st each year) and the pneumonia vaccine to residents within three days of admission. The IP stated she was new to the facility and did not know what system was in place before she arrived. The IP reviewed Residents 37, 61, 67, and 70's medical records and noted the following discrepancies: -For Resident 37, no documentation if the resident had received the flu vaccine or not. The consent for the pneumonia vaccine was obtained after surveyor inquired. -Resident 61 signed a consent to receive the flu vaccine on 10/5/2020, however, the IP stated the vaccine was never administered. -For Resident 67, the IP stated she could not find any documents to indicate whether Resident 67 had been offered the flu or pneumonia vaccine in the last year -For Resident 70, the IP stated she could not find any documentation to indicate whether Resident 70 had consented or received the flu or pneumonia vaccine. The IP acknowledged the facility did not have a system in place to track screening of residents for eligibility, provide education about the vaccines and did not have a process to follow up and consistently track whether eligible residents had received the flu and/or pneumonia vaccines. The IP stated she planned to work with the Director of Staff Development to develop a better tracking system. During a review of the facility's policy and procedure (P/P), titled, Influenza Prevention and Control, dated 9/10/2020, the P/P indicated the purpose of the P/P was to prevent and control the spread of influenza in the facility. The P/P indicated each resident or the resident's representative would be given education regarding the risk and benefits of the vaccine, including potential side effect of the vaccine, the resident or representative must give consent or refusal of vaccine, and the information would be documented in the residents' medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P), titled, Pneumococcal Disease Prevention, dated 2/18/2021, the P/P indicated the facility would provide education about pneumococcal vaccination, obtain consent or refusal, and administer the vaccine per the Centers for Disease and Prevention (CDC) guidelines.

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41489 Based on observation, interview and record review, the facility failed to ensure the call light system was operable with visual and audible in all of the residents' rooms, bathrooms, and at the nursing stations, to alert and relay the residents' needs to the staff for 19 of 19 residents (Residents 5, 10, 11, 14, 21, 23, 26, 43, 47, 52, 53, 63, 77, 80, 81, 83, 88, 89, and 98) with a universe of 94, and had the potential to affect all the residents who resided in the facility. During a review of the facility's Resident Census and Conditions of Residents (CMS 672 form) completed by the facility, the CMS 672 indicated the facility had 60 residents occasionally or frequently were incontinent (inability to control) of bladder; 68 residents occasionally or frequently were incontinent of bowel; 68 residents with contractures (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints); 62 residents receiving preventative skin care; 28 resident who require suctioning; and 19 residents on a pain management program. This deficient practice of the facility's inoperable call light system had the potential to result in adverse consequences to the residents (Residents 5, 10, 11, 14, 21, 23, 26, 43, 47, 52, 53, 63, 77, 80, 81, 83, 88, 89, and 98) due to not having the ability to communicate their needs and needs met timely. During an annual recertification survey on 7/7/2021 at 3 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident or residents) was identified and declared and the facility's administrator (ADM) and Director of Nursing (DON) were informed of the facility's non-compliance to ensure the call light system was operable to meet the residents' needs. During an interview on 7/9/2021 at 2:11 p.m., the ADM and the DON were informed the IJ was lifted after implementation of the acceptable plan of action ([POA], interventions to correct the deficient practice) was verified and confirmed while on onsite via observation, interview and record review. The acceptable POA included the following actions: 1. On 7/6/2021, the Assistant DON (ADON) conducted room rounds to the affected residents' rooms to ensure residents' needs were attended and to ensure safety of residents. 2. On 7/6/2021, the Licensed Nurses provided call bells to the affected residents with call lights malfunction, who can utilize them. 3. On 7/6/2021, the maintenance supervisor immediately repaired the call lights malfunction and was resolved within 5 minutes. 4. On 7/6/21 and 7/7 /21, a total of 29 residents located from rooms 31 through 42, were identified to be affected by the call light malfunction. 5. On 7/7/2021: (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Maintenance Supervisor immediately repaired the call lights malfunction and was resolved within 2 hours. b. The ADM called an outside company to come into the facility to check the call light systems and ensure the affected call lights were fixed c. The DON/Designee, informed the affected residents with call light malfunction and provided education to the residents on how to use the call bell for those residents who were able to utilize the call bells and provided 1:1 monitoring for those residents who refused to utilize the manual call bell and are unable to utilize the manual call bell. d. The DON together with the Licensed Nurses, immediately assessed the residents with call lights malfunction to ensure resident's safety and immediate needs were attended. e. The DON/Designees conducted hourly monitoring of the affected residents with malfunction call lights to ensure residents' safety and needs are being attended such a toileting, turning and repositioning, activities of daily living (ADL) care, nutrition, and hydration needs. The Minimum hourly rounds is based on the residents' conditions and individual needs and if there is a change of condition, the monitoring could be much more frequent such as for those residents who are total dependent residents, residents who are risk for falls, have behaviors, the Licensed Nurse can increase the monitoring frequency. f.Licensed Nurses and Certified Nursing Assistants (CNAs) provided call bells to the affected residents with call light malfunction, who can utilize them. g. The Facility Staff were assigned in each room of the affected hallway and were readily available to respond and ensure resident's safety and needs are attended. h. The [NAME] President of Operations submitted a request for quotes to replace the entire call light system of the facility. i. The DSD initiated an in - service education to the facility staff - licensed nurses, CNAs, Restorative Nursing Assistants (RNAs), Rehab Department, Respiratory Therapist, Housekeeping, Laundry, Maintenance, Kitchen, Social Services, Activities, Business Office and Receptionist, regarding the policy and procedures for Communication - Call System and discussed the facility's performance improvement an j. The maintenance supervisor and will document hourly rounds {See enclosed) daily during the day between 9am and 5 pm (Monday to Friday) to ensure call lights are functioning until the call lights system is replaced, installed, and functioning. Any identified concerns will be addressed and reported to the Administrator and DON. k. The RN Supervisors/Designee will document hourly rounds daily from 5 pm to 9 am and on the weekends 24 hours/day to ensure call lights are functioning until the call lights system is installed and replaced. Any identified concerns will be addressed and reported to the Administrator and DON. 6. Once the new call light system is installed, the maintenance supervisor and/ or designee will continue to monitor daily x2/ per day for 2 weeks. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. The Department Managers will be assigned to designated rooms for daily rounds and will interview residents and/or family members daily (Monday-Friday) and RN Supervisors during the weekends to ensure that residents' needs are attended. Any concerns identified will be addressed and reported to the Administrator for further resolution as warranted. 8. The maintenance supervisor will conduct hourly rounds daily during the day between 9 am and 5 pm (Monday to Friday) to ensure call lights are functioning until the entire call lights system is replaced, installed, & functioning. Any identified concerns will be addressed and reported to the Administrator and DON. 9. The Administrator will present the results of the call light audits to the Quality Assurance and Performance Improvement Committee monthly for the next 3 months, then quarterly thereafter until substantial compliance is sustained. 10. The Administrator and the Director of Nursing are responsible to ensure sustained compliance. Findings: During observations of the initial tour of the facility on 7/6/2021 at 10:50 a.m., in rooms 36-42, the call lights had no audible sound heard and light not flashing inside or outside residents' room after activating the system. During a review of Resident 14's Admission Record (Face Sheet), the Face Sheet indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included dementia (disorder of the mental processes caused by brain disease or injury and marked by memory disorders , personality changes, and impaired reasoning), paranoid schizophrenia (mental disorder involving breakdown in relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions or feelings, and withdrawal from reality), and muscle weakness. During a review of Resident 14's Minimum Data Set (MDS), a resident assessment and care-planning tool, dated 5/28/2021, the MDS indicated Resident 14 was moderately impaired cognitively (thought). The MDS indicated Resident 14 required extensive assistance of one person-physical assist to provide weight bearing support to move to from the bed to wheelchair or standing position, use the toilet, to get dressed, and to maintain personal hygiene. During a review of Resident 14's care plan titled, At risk for falls, the care plan indicated Resident 14 had limited mobility, poor balance, lack of awareness, was incontinent, and had cognitive deficits. The care plan also indicated Resident 14's call light to be kept within reach and remind resident to use the call light. During a review of Resident 14's care plan titled, Activities of daily living, updated 4/17/2021. The care plan indicated Resident 14 required assistance with walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. During an interview on 7/6/2021 at 10:37 a.m., Resident 14 was nodding her head for a yes or no as an answer to questions during the interview to answer questions. Resident 14 nodded her head indicating the staff do not come right away when she presses the call light to ask for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055077	A. Building B. Wing	07/13/2021

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

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 52's Face Sheet, the face sheet indicated Resident 52 was admitted to the facility on [DATE]. Resident 52's diagnoses included respiratory failure (condition in which blood does not have enough oxygen or has too much carbon dioxide), cognitive communication deficit, difficulty walking, need for assistance with personal care, and seizures (burst of uncontrolled electrical activity between brain cells that causes stiffness, twitching or limpness) disorder. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 had severely impaired cognitive skills. The MDS also indicated Resident 52 was totally dependent on staff seven days a week for assistance with moving in bed, getting dressed, eating, personal hygiene, bathing, and toilet use. During a review of Resident 52's care plan titled, At risk for falls the care plan indicated Resident 52 had limited mobility, poor balance, lack of awareness, was incontinent, had a history of falls, and had communication deficits. The care plan also indicated Resident 52's call light to be kept in reach and to remind her to use the call light. During a review of Resident 88's Face Sheet, the face sheet indicated Resident 88 was admitted to the facility on [DATE]. Resident 88's diagnoses included respiratory failure (a condition that causes difficulty breathing), muscle weakness, and hypertension (high blood pressure). During a review of Resident 88's MDS, dated [DATE], the MDS indicated Resident 88 had severe cognitive impairment and was rarely/never understood. During an observation on 7/6/2021 at 10:41 a.m., Resident 14's call light was tested unsuccessfully, and indicator light appeared outside of the door, there was no audible sound heard and the call light cancel light did not flash inside Resident 14's room. During an interview on 7/6/2021 at 10:44 a.m., Certified Nursing Assistant 1 (CNA 1) stated and confirmed Resident 14's call light was not working. During an interview on 7/6/2021 at 11:24 a.m., Housekeeper (HS 2) stated the facility's electrical breaker had a malfunction earlier, which cause the call lights to malfunction. During an observation on 7/7/2021 at 9:54 a.m., the Director of Staff Development (DSD) tested the call lights in rooms 31-42 and confirmed Residents' 63, 47, 88, 10, 14, 89, 5, 21, 98, 43, 83, 81, and 53 call lights were not functioning. During an interview on 7/7/2021 at 10:47 a.m., CNA 6 stated and acknowledged he was unable to hear the call lights at the nurses' station panel during checks. CNA 6 stated the residents were given bells to use until the call light were fixed and if the residents were unable to move, rounds were made often to check on residents. CNA 6stated having inoperable call lights places the residents at risk for falls. During an interview on 7/7/2021 at 11:10 a.m., CNA 7 stated call lights were checked at the start of each and if a call light was found to be malfunctioning, the maintenance supervisor was made aware. CNA 7 stated he tells the residents to yell out if their call lights are not working, and if they cannot talk, he checks often on the residents. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview on 7/7/2021 at 11:35 a.m. CNA 8 tested the call light located in room [ROOM NUMBER]. CNA 8 acknowledged the Nurse's station was not visible from room [ROOM NUMBER] and she could not see if the call light was buzzing at the nurse's station. CNA 8 stated she was unaware the call lights were not working. CNA 8 stated, We cannot always hear the resident calling but there are other staff in the hallway and the hallway is never empty. Residents can fall if not attended to right away. The call lights are important. During an interview on 7/7/2021 at 12:02 p.m., the DSD stated all staff were responsible for answering the call lights and the call lights should be answered immediately and not ring for more than 2-3 minutes. The DSD stated if the CNA could not provide service at the time the call light was pressed by the resident, then the CNA has to get another staff to address the concern and inform the residents someone would be returning to address their concerns. The DSD stated CNA's conduct rounds and call light check at the start of their shift and ensure call lights are within reach and functional. The DSD stated it was the job of the CNAs to notify maintenance right away of the call lights malfunction and conduct hourly rounds. During an interview on 7/7/2021 at 12:13 p.m., the Director of Maintenance (DOM) stated, We test the call lights once a day. We test the lights outside of each door, inside each room and at nurse's station. This issue of the call lights being broken, started yesterday (7/6). We believe the capacitor (a device that stores electrical energy) overheated so today and the technician is coming to fix the problem. I don't think we have a backup system. I'm new here. We have parts for cords; however, we communicate work orders by group text and department heads. During an interview on 7/7/2021 at 1:30 p.m., the ADON stated rooms 31 to 41 call lights were not functioning. The ADON stated the MS was informed of the call lights malfunctioning and handed out tabletop bells to the residents who had broken call lights. The ADON stated the facility had the same call lights from rooms 31 to 42 malfunctioning. The ADON stated the purpose of the call light was for nurses to be available when residents have needs. Residents can't call for help or get the care they need if the calls were not working. During an interview on 7/8/2021 at 10:39 a.m., the Medical Director (MD) stated call light malfunctioning has been brought up before in Quality Assurance and Performance Improvement ([plan discussed to improve health care delivery and resident quality of life] QUAPI) meetings. The MD also stated the facility informed her today the call light system was going to be replaced. During review of undated facility's record under section, List of Residents requires adaptive equipment/call light alternative indicated seven (7) residents required a call light alternative. During a review of the facility's Direct Supply Tels: Logbook Documentation indicated the call lights were last tested on [DATE]. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility's policy and procedures (P/P), titled, Communication - Call System, dated 1/1/2012, the P/P indicated the purpose of the P/P was to provide a mechanism for residents to promptly communicate with Nursing Staff. The P/P indicated the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Nursing Staff will answer call bells promptly, in a courteous manner. In answering to request, Nursing Staff will return to the resident with the item or reply promptly. Assistance will be offered before leaving. The P/P also indicated if call bell is defective, it will be reported immediately to maintenance and replaced immediately. The P/P indicated call bells located within the resident bathrooms are considered emergency calls due to the potential for falls and injury. These lights have more frequent audio sound and the call light above the room door may be red or will flash on and off. Emergency calls must be answered promptly. The P/P further indicated adaptive call bells will be provided to resident per resident's needs.