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 _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL COVE POST ACUTE	1730 GRAND AVE LONG BEACH, CA 90804

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during complaint and facility reported incident survey. Complaint Number: CA00926651, CA00926536, and CA00927731. Facility Reported Incident Numbers: CA00928261. The inspection was limited to the specific complaint and Facility Reported Incidents investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for the Facility Reported Incident number: CA00928261 (Refer to Ftags 609 and F610). No deficiency was issued forComplaint number: CA00926651, CA00926536, CA00927731.	F 000	**Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483."** **This Plan of Correction constitutes Grand Avenue Healthcare and Wellness Center credible allegation of compliance for the alleged deficient practices.**	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609	**FTAG 609 Reporting of Alleged Violations** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** • On 11/01/24 The allegation of abuse was reported to CDPH, Law Enforcement and ombudsman	11/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K B Rodriguez | TITLE: ADON | (X6) DATE: 11/22/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) no later than two hours for one of one sampled resident (Resident 1) when Resident 2 pulled Resident 1 ' s beanie (small close fitting hat) off her head and had her hair pulled. This failure had the potential to result in unidentified abuse in the facility and the failure to protect residents from abuse. Findings During a review of Resident 1 ' s Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on 9/6/2022 and readmitted on 9/22/2024 with diagnoses including multiple sclerosis (nerve damage disrupting communication between the brain and body), heart failure (heart muscle is unable to pump	F 609	• On 11/1/24 Resident was assessed by license nurse for any untoward effects. • On 11/1/24 The Resource Nurse provided an in-service to license nurses who first had knowledge of the allegation of abuse reporting with emphasis on reporting all alleged violations involving abuse, neglect, are reported to the department of public health and other appropriate agencies by mandated reporters no later than 2 hours. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** • On 11/1/24 Department Managers conducted rounds and interviews of residents to identify residents with concerns related to abuse allegations to ensure all allegations are reported	

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F 609	Continued From page 2	F 609		

enough blood to meet the body ' s needs for blood and oxygen), and muscle weakness.

During a review of Resident 1 Minimum Data Set (MDS a federally mandated resident assessment tool), dated 5/23/2024 indicated Resident 1 was independent in making decisions for herself.

During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on 2/08/2024 and readmitted on 6/19/2024 with diagnoses including schizoaffective disorder ((a mental illness that can affect thoughts, mood, and behavior), depression (mental health condition that involves a persistent low mood or loss of interest in activities) , restlessness and agitation, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs),chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).

During a review of Resident 2 ' s MDS dated 8/23/2024, the MDS indicated, Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment.
During a review of Resident 2 ' s Change of Condition Evaluation dated 10/29/2024, indicated Resident 2 was transferred to general acute care hospital (GACH) on 10/29/2024 for continuously pulling the fire alarm and becoming physically and verbally aggressive with the staff.

During an interview on 10/31/2024 at 5:50 a.m., with Resident 1, Resident 1 stated that 2 days ago (10/29/2024) while on the smoking patio around 6:30 p.m., Resident 2 pulled her beanie

within 2 hours and that they are thoroughly investigated No other residents were found affected by the same deficient practice.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

- On 11/1/24 Resource Nurse/Designee provided an in-service to the staff on abuse reporting with emphasis on reporting all alleged violations involving abuse, neglect, are reported to the department of public health and other appropriate agencies by mandated reporters no later than 2 hours.
- On 11/1/24 and 11/4/24 Resource Nurse/Designee provided re-education to the department managers on abuse reporting with emphasis on reporting all alleged violations involving abuse, neglect, are reported to the department of public

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F 609	Continued From page 3	F 609		

off her head and pulled her hair. Resident 1 stated she told the Administrator (ADM) the next day (10/30/2024).

During a phone interview on 11/1/2024 at 11:30 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 2 did take the beanie off Resident 1 ' s head on 10/29/2024. CNA 1 stated that Resident 1 and Resident 2 were separated, and CNA 1 reported it to the Licensed Vocational Nurse (LVN).

During an interview on 11/1/2024 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that CNA 1 did report to him that Resident 2 pulled Resident 1 ' s beanie off her head and that Resident 1 was mad. LVN 1 stated both residents were separated. LVN 1 stated he forgot to report it to the Administrator (ADM) because he had a lot of work to do that day (10/29/2024). LVN 1 stated, he was a mandated reporter and should have reported the incident. LVN 1 stated it was his obligation to report any allegation of abuse to ensure resident and staff safety and prevent further abuse.

During a phone interview on 11/1/24 at 3:35 p.m., with the ADM, the ADM stated that any allegation of abuse should be reported within two hours to CDPH. The ADM stated the incident between Resident 1 and Resident 2 was not reported to him. The ADM stated all allegations of abuse should be reported and investigated to ensure resident ' s safety and that residents deserve to live in an abuse free environment.

During a review of the facility ' s policy and procedure (P&P) titled " Abuse Prevention and Management" dated /12/2024, indicated, "The

health and other appropriate agencies by mandated reporters no later than 2 hours.

How the facility plans to monitor its performance to make sure that solutions are sustained:

- The Department Managers will conduct rounds to identify resident concerns or abuse allegations and to ensure that abuse allegations are reported immediately weekly for 4 weeks then bimonthly for 2 months. Identified concerns will be reported immediately to the Administrator and DON for follow up and resolution.
- The Administrator/ DON/Designee will be responsible for monitoring and sustaining compliance.
- The Administrator/Designee will present the results of the Audits to the Quality Assurance and Performance

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F 609	Continued From page 4 Administrator or designated representative will notify law enforcement by telephone immediately, or as soon as practicably possible, but no longer than 2 hours of an initial report and send a written SOC 341 report to the Ombudsman, Law Enforcement, and California Department of Public Health (CDPH) within two hours."	F 609	Improvement Committee for monthly review and recommendations for the next 3 months or until substantial compliance is achieved.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to submit a five-day investigative report for one of one sampled resident's (Resident 1). This deficient practice resulted in an incomplete investigation and incomplete conclusion of the	F 610	**Completion Date:** • **11/22/24** **FTAG 610** **Investigate/Prevent/Correct Alleged Violation** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** • On 11/1/24 and 11/4/24 The Administrator provided an in-service to the department managers relating to abuse reporting to ensure IDT conducts and documents timely and thorough investigations into	11/22/24

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F 610	Continued From page 5 alleged abuse in the facility. Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on 9/6/2022 and readmitted on 9/22/2024 with diagnoses including multiple sclerosis (nerve damage disrupting communication between the brain and body), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and muscle weakness. During a review of Resident 1 Minimum Data Set (MDS a federally mandated resident assessment tool), dated 5/23/2024 indicated Resident 1 was independent in making decisions for herself. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on 2/08/2024 and readmitted on 6/19/2024 with diagnoses including schizoaffective disorder ((a mental illness that can affect thoughts, mood, and behavior), depression (mental health condition that involves a persistent low mood or loss of interest in activities), restlessness and agitation, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs),chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 2's MDS dated 8/23/2024, the MDS indicated, Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment.	F 610	allegations of abuse and takes corrective action as appropriate. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** • On 11/1/24 Department Managers conducted rounds and interviews of residents to identify any residents with concerns related to any abuse allegations to ensure all allegations are thoroughly investigated and reported. No other residents were found affected by the same deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** • On 11/1/24 and 11/4/24 The Resource Nurse/Designee provided an in-service to the	

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F 610	Continued From page 6 During a review of Resident 2's Change of Condition Evaluation dated 10/29/2024, indicated Resident 2 was transferred to general acute care hospital (GACH) on 10/29/2024 for continuously pulling the fire alarm and becoming physically and verbally aggressive with the staff. During an interview on 10/31/2024 at 5:50 a.m., with Resident 1, Resident 1 stated that 2 days ago (10/29/2024) while on the smoking patio around 6:30 p.m., Resident 2 pulled her beanie off her head and pulled her hair. Resident 1 stated she told the Administrator (ADM) the next day (10/30/2024). During a phone interview on 11/1/2024 at 11:30 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 2 did take the beanie off Resident 1's head on 10/29/2024. CNA 1 stated that Resident 1 and Resident 2 were separated, and CNA 1 reported it to the Licensed Vocational Nurse (LVN). During an interview on 11/1/2024 at 11:45 a.m., with LVN 1, LVN 1 stated that CNA 1 did report to him that Resident 2 pulled Resident 1's beanie off her head and that Resident 1 was mad. LVN 1 stated both residents were separated. LVN 1 stated he forgot to report it to the Administrator (ADM) because he had a lot of work to do that day (10/29/2024). LVN 1 stated, he was a mandated reporter and should have reported the incident. LVN 1 stated it was his obligation to report any allegation of abuse to ensure resident and staff safety and prevent further abuse. During a phone interview on 11/1/24 at 3:35 p.m., with the ADM, the ADM stated all allegations of abuse should be investigated and results of	F 610	department managers relating to abuse reporting and investigation to ensure the IDT conducts and documents timely and thorough investigations into allegations of abuse and takes corrective action as appropriate. **How the facility plans to monitor its performance to make sure that solutions are sustained:** • The Department Managers will conduct rounds to identify resident concerns or abuse allegations and to ensure that abuse allegations are reported immediately and are thoroughly investigated weekly for 4 weeks then bimonthly for 2 months. Identified concerns will be reported immediately to the Administrator and DON for follow up and resolution. • The Administrator/ DON/Designee will be	

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F 610	Continued From page 7 investigation reported to the administrator within five working days of the incident. During a review of the facility's policy and procedure (P&P) titled "Abuse Prevention and Management" dated 6/12/2024, indicated, "The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification and others that may be required by state or local laws, within five working days of the reported allegation.	F 610	responsible for monitoring and sustaining compliance. • The Administrator/Designee will present the results of the Audits to the Quality Assurance and Performance Improvement Committee for monthly review and recommendations for the next 3 months or until substantial compliance is achieved. **Completion Date:** • **11/22/24**	