

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Coventry Court Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2040 S. Euclid Avenue Anaheim, CA 92802	
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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46937 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were coordinated to meet the resident's needs when discharged from the facility for one of two sampled residents (Resident 1). This failure resulted in Resident 1 not having appropriate care at home, which had the potential to negatively affect Resident 1's health. Findings: Review of the facility's P&P titled Criteria for Transfer and Discharge revised 2/2023 showed upon a resident's discharge the facility must provide information to the receiving provider, which must include a minimum of the following: contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of the facility's P&P titled Job Description Social Service Manager dated 11/2021 showed the Social Service Manager's responsibilities include: to participate in discharge planning, refer the resident/families to appropriate social services agencies when the facility does not provide the services or needs of the resident, provide information to resident/families as to Medicare/Medicaid, and other financial assistance programs available to the resident, and provide direct assistance and support to residents/families with the process of application, submission, and coordination with the relevant programs and their offices. Closed medical record review for Resident 1 was initiated on 9/18/24. Resident 1 was admitted to the facility on [DATE], and discharged to home on 9/5/24. Resident 1 was dependent on staff to complete her ADL cares. Review of Resident 1's H&P examination dated 9/1/24, showed Resident 1 had lower extremity paralysis related to breast cancer with spinal metastasis. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS Score of 15 and had no cognitive impairment. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055983	Facility ID: 055983 If continuation sheet Page 1 of 3

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's social services Care Plan for discharged initiated on 3/4/24, showed the facility should arrange Resident 1's community resources to support independence with post discharge home care. The facility needed to provide Resident 1 or her family member with the contact numbers for all community referrals. Resident 1 needed written instructions and visual aids, as required, to ensure care continuity post discharge. Review of Resident 1's recapitulated Order Summary Report for September 2024 showed a physician's order dated 9/4/24, to discharge Resident 1 to home with palliative care per the family's request. The order also showed for the DME to be delivered at home. Review of Resident 1's Social Services Progress Notes for March to September 2024 showed the following progress notes: - On 9/4/24, Resident 1 was seen by the physician on 9/1/24, and expressed her desire to go home. The physician discussed and agreed with Resident 1's discharge plan. Resident 1 wished to be discharged home with palliative care. Resident 1 signed the consents and her DME was coordinated for home. The note showed Resident 1 was to be discharged by 9/5/24 at noon. - On 9/10/24, the SSD called the outside services to follow up on a referral for Resident 1's home services. The SSD was unable to get in contact with the outside service's case manager and left a voice message. Further review of the social services progress notes failed to show documentation Resident 1's palliative care was coordinated and confirmed to provide the services at the resident's home. There was no contact information for Resident 1's palliative care agency. Review of Resident 1's Discharge Summary and Post-Discharge Plan of Care (instructions provided to Resident 1 upon discharge) dated 9/5/24, showed Resident 1 was discharged home on 9/5/24, with palliative care. Resident 1 was non-ambulatory and required extensive assistance with ADL cares. Resident 1 had MASD in her sacral to medial buttocks, an unstageable wound on her left lateral heel, and generalized body itchiness. The Discharge Summary and Post-Discharge Plan of Care showed Resident 1 needed an ongoing skin treatment. Additionally, Resident 1 had an indwelling urinary catheter and was provided supplies for home. The Discharge Summary and Post-Discharge Plan of Care showed Resident 1 was discharged with palliative care; however, the instructions failed to show documentation of the palliative care agency's contact person, phone number, and address. Under the section for medical equipment/devices ordered, the Discharge Summary and Post-Discharge Plan of Care indicated no medical equipment/devices were ordered for Resident 1. On 9/18/24 at 1139 hours, an interview was conducted with Resident 1. Resident 1 stated she was discharged home from the facility on 9/5/24, per her request. Resident 1 stated she informed the facility about two weeks prior to 9/5/24, that she wanted to be discharged with palliative care services. When asked what services she needed for home, Resident 1 stated she needed a caregiver at least twice daily because she was immobile, and her husband was unable to fully support her care due to his disabilities. Prior to discharge, Resident 1 stated the SSD informed her that the palliative care agency was confirmed for care at home; however, Resident 1 stated no one came in to provide care or supplies when she arrived home. Resident 1 stated she had to call and set up home care services herself after she was discharged from the facility. (continued on next page)		

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 1427 hours, an interview and concurrent closed clinical record review was conducted with the SSD. The following was discussed: - When asked about the process for discharge, she stated once the physician cleared a resident for discharge, the social services department set up the home service agency, such as palliative care, as ordered prior to discharge. The contact information for the home service agency was provided to a resident in their discharge information packet. When asked how the palliative care agency knew what a resident's discharge needs were, the SSD stated the palliative care agency was responsible for assessing a resident and ordering any medical services and DME prior to discharge. When asked how the home service agencies were provided the report on a resident's care, the SSD stated the palliative care agency received the report and obtained records from the facility about the resident prior to discharge. - When asked about Resident 1, she stated she oversaw Resident 1's discharge. Resident 1 informed her that she wanted to go home with palliative care. When asked how Resident 1's palliative care was coordinated, the SSD stated Resident 1 found the palliative care agency and set up the services herself. When asked if she provided Resident 1 with information on other home service agency options, such as home health or hospice, the SSD stated no because Resident 1 was adamant about receiving palliative care; Resident 1 informed her that she already did her own research. When asked if she had documentation regarding her conversation with Resident 1, the SSD stated no. The SSD stated she assisted Resident 1 to log on to a portal to sign up for palliative care. When asked if she received a case number or confirmation notification to show Resident 1's palliative care services were confirmed for home, the SSD stated no. When asked if the palliative care agency coordinated with the facility and obtained report on Resident 1's discharge needs, the SSD reviewed Resident 1's medical record and stated she did not have documented evidence the palliative care agency contacted the facility to coordinate care. The SSD stated she did not recall if she called Resident 1's palliative care agency to coordinate care or confirm coordination was completed. She did not have the contact information for Resident 1's chosen palliative care agency. On 9/23/24 at 1325 hours, an interview was conducted with the ADON/IP. The ADON/IP stated she assisted the floor nurses as needed with discharge. When asked about the discharge process, the ADON/IP stated the physician initiated discharge and placed an order for home services or DME as needed. Upon receipt of an order, the nursing coordinated with the SSD to ensure discharge resources were provided to a resident. The ADON/IP stated the SSD was responsible for ensuring home services and DME were confirmed prior to discharge. If a resident was ordered palliative care, the SSD should have coordinated for palliative care to meet with nursing and receive clinical report. On 9/23/24 at 1517 hours, an interview was conducted with the Administrator and DON. When asked who was responsible for coordinating the resident discharges, the Administrator stated the SSD oversaw the resident discharges. The Administrator and DON were informed of the above findings. The Administrator stated they spoke to Resident 1 about her discharge multiple times, and she insisted she wanted to go home with palliative care. On 9/23/24 at 1527 hours, the Administrator called the SSD to ask about Resident 1's discharge. The SSD stated Resident 1 found the palliative care company herself; however, upon review of their documentation, the Administrator acknowledged there was no documented evidence of their conversations with Resident 1.		