STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055983	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry Court Health Center	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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's current care needs and interventions for one of three sampled residents (Resident 1). * The facility failed to ensure Resident 1's plan of care was revised to address Resident 1's refusal of insulin as ordered by the physician for the management of diabetes mellitus. This failure has the potential to pose the risk of not providing Resident 1 with appropriate and individualized care. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care revised 12/2023 showed the facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident. Closed medical record review for Resident 1 was initiated on 8/22/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/14/25, showed Resident 1 was admitted to the facility with diagnoses including Type 2 Diabetes and had the capacity to understand and make medical decisions. Review of Resident 1's Order Summary Report showed a physician's order dated 4/15/25, for Resident 1 to receive insulin Glargine Solution (antidiabetic) 100 units/ml 12 units subcutaneously at bedtime for diabetes. Hold for blood sugar less than 90 mg/dl. Review of Resident 1's MAR from April to June 2025 showed the following nursing documentation with the designated chart code 1: refusal, 10: hospitalized and 14: no insulin required:- dated 4/15/25, BS (blood sugar) of 136 mg/dl, chart code 1 - dated 4/16/25, BS of 133 mg/dl, chart code 1- dated 4/17/25, BS of 151 mg/dl, chart code 1- dated 4/18/25, BS of 146 mg/dl, chart code 1- dated 4/21/25, BS of 134 mg/dl, chart code 1- dated 4/27/25, BS of 127 mg/dl, chart code 1- dated 4/28/25, BS not available, chart code 1- dated 4/29/25, BS of 144 mg/dl, chart code 1- dated 5/1/25, BS of 116 mg/dl, chart code 1- dated 5/2/25, BS of 185 mg/dl, chart code 1- dated 5/3/25, BS of 166 mg/dl, chart code 1- dated 5/4/25, BS of 136 mg/dl, chart code 1- dated 5/5/25-5/7/25, BS not available, chart code 1- dated 5/8/25, BS of 178 mg/dl, chart code 1- dated 5/9/25, BS not available, chart code 1- dated 5/10/25, BS of 114 mg/dl, chart code 1- dated 5/11/25, BS of 148 mg/dl, chart code 1- dated 5/12/25-5/14/25, BS not available, chart code 1- dated 5/15/25, BS of 128 mg/dl, chart code 1- dated 5/16/25, BS not available, chart code 1- dated 5/17/25, BS of 116 mg/dl, chart code 1- dated 5/18/25, BS of 127 mg/dl, chart code 1- dated 5/19/25-5/21/25, BS not available, chart code 1- dated 5/22/25, BS of 173 mg/dl, chart code 1- dated 5/23/25-5/28/25, BS not available, chart code 1- dated 5/29/25, BS of 150 mg/dl, chart code 1- dated 5/30/25, BS of 90 mg/dl, chart code 14- dated 6/1/25, BS of 150 mg/dl, chart code 1- dated 6/2/25, BS not available, chart code 1- dated 6/3/25, BS not available, chart code 1- dated 6/4/25, BS not available, chart code 1 Review of Resident 1's plan of care for Diabetes mellitus initiated on 4/28/25, showed interventions included checking the blood sugar and administering insulin as ordered. However, the plan of care was not revised to reflect Resident 1's refusal of the medication and education with risks associated with the refusal. On 8/26/25 at 1242 hours, an interview and concurrent closed medical record review was conducted with MDS Nurse 1. MDS Nurse 1 verified the above findings. MDS Nurse 1 stated Resident 1's plan of care interventions should have been updated to reflect Resident 1's refusal of the medication as ordered, ongoing monitoring of resident's glucose level and risks associated with medication refusal for the treatment and management of diabetes. On 8/26/25 at 1605 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON acknowledged and verified the above findings.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 1) attained and maintained their highest practicable physical well-being. * The facility failed to notify the physician when Resident 1 consistently refused insulin as ordered. This failure posed the risk of Resident 1 not being provided with appropriate care and monitoring of possible complications associated with diabetes mellitus.Findings: Review of the facility's P&P titled Diabetes Management dated 5/2019 showed medications for diabetes will be administered as ordered by the physician including oral hypoglycemic or insulin. Review of the facility P&P titled Administration of Medication (undated) showed medications must be administered in accordance with the written orders of the attending physician. Should a drug be withheld, refused or given other than at the scheduled time, the staff administering must indicate the reason on the MAR. For those utilizing eMARs, the appropriate code must be entered with follow up documentation as appropriate for the situation. Closed medical record review for Resident 1 was initiated on 8/22/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/14/25, showed Resident 1 was admitted to the facility with diagnoses including Type 2 diabetes and had the capacity to understand and make medical decisions. Review of Resident 1's Order Summary Report showed a physician's order dated 4/15/25, for Resident 1 to receive insulin Glargine Solution (antidiabetic) 100 units/ml 12 units subcutaneously at bedtime for diabetes. Hold for blood sugar less than 90. Review of Resident 1's MAR from April to June 2025 showed the following nursing documentation with the designated chart code 1: refusal, 10: hospitalized and 14: no insulin required:- dated 4/15/25, BS of 136 mg/dl, chart code 1 - dated 4/16/25, BS of 133 mg/dl, chart code 1- dated 4/17/25, BS of 151 mg/dl, chart code 1- dated 4/18/25, BS of 146 mg/dl, chart code 1- dated 4/21/25, BS of 134 mg/dl, chart code 1- dated 4/27/25, BS of 127 mg/dl, chart code 1- dated 4/29/25, BS of 144 mg/dl, chart code 1- dated 5/1/25, BS of 116 mg/dl, chart code 1- dated 5/2/25, BS of 185 mg/dl, chart code 1- dated 5/3/25, BS of 166 mg/dl, chart code 1- dated 5/4/25, BS of 136 mg/dl, chart code 1- dated 5/8/25, BS of 178 mg/dl, chart code 1- dated 5/10/25, BS of 114 mg/dl, chart code 1- dated 5/11/25, BS of 148 mg/dl, chart code 1- dated 5/15/25, BS of 128 mg/dl, chart code 1- dated 5/17/25, BS of 116 mg/dl, chart code 1- dated 5/18/25, BS of 127 mg/dl, chart code 1- dated 5/22/25, BS of 173 mg/dl, chart code 1- dated 5/23/25-5/28/25, BS not available, chart code 1- dated 5/29/25, BS of 150 mg/dl, chart code 1- dated 5/30/25, BS of 90 mg/dl, chart code 14- dated 6/1/25, BS of 150 mg/dl, chart code 1- dated 6/2 to 6/4/25, BS not available, chart code 1Further review of Resident 1's medical record failed to show documented evidence the physician was notified of the resident's consistent refusal of insulin. On 8/26/25 at 1242 hours, an interview and concurrent closed medical record review was conducted with MDS Nurse 1. MDS Nurse 1 verified the above findings. MDS Nurse 1 stated there should have been documentation to show the physician was informed regarding refusal of medication or treatment as ordered. On 8/26/25 at 1605 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON acknowledged and verified the above findings.