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	09/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 care plan reflected the individual care needs for one of six sampled residents (Resident 1). * The facility failed to provide adequate monitoring when Resident 1 was continually wandering around the facility to prevent elopement and/or accidents. In addition, the facility failed to develop a person-centered care plan to address Resident 1's high risk for elopement and fall. This failure resulted to Resident 1 being unsupervised and had a fall with injury in the patio.Findings: Review of the facility's P&P titled Fall Management System revised 4/2025 showed it is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Review of the facility's P&P titled Comprehensive Resident Centered Care Plan revised 1/2021 showed the IDT shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that include measurable objectives and timeframes to meet a resident/'s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Closed medical record review for Resident 1 was initiated on 9/24/25. Resident 1 was admitted to the facility on [DATE], and was discharged on 9/7/25. Review of Resident 1's Elopement/Wandering Evaluation dated 8/19/25, showed the resident was high risk for elopement wandering. Resident 1 had a predisposing disease of dementia (brain disorders that cause a progressive decline in cognitive abilities). The section for History of elopement in the last six months showed a yes response to the following questions:- does resident makes statements about a desire to leave the facility, etc.;- does the wandering place the resident at risk of getting to a potentially dangerous place (stairs, outside the facility); and- does the wandering significantly intrude on the privacy or activities of others. Review of Resident 1's Fall Risk Evaluation dated 8/19/25, showed the resident was categorized as high risk for falls. Review of Resident 1's Care Plan Report showed a care plan problem was initiated on 8/19/25, to address the following:- at risk for repeat falls, the interventions included to provide redirection and cuing when the resident wheels self around;- potential for injury related to exit seeking behavior and risk for elopement, the interventions included to monitor the resident's whereabout; and- elopement risk/wanderer related to impaired safety awareness and exit seeking behavior. However, the elopement care plan showed the goals and interventions were developed only on 8/28/25, when Resident 1 had a fall in the patio. Review of Resident 1's MDS assessment dated [DATE], showed the following:- section C for Cognitive Patterns showed Resident 1 had a BIMS score of 5 (severe cognitive impairment); and- section GG for Functional Abilities showed Resident 1 had no impairment on upper and lower extremity and uses wheelchair for mobility device. Review of Resident 1's Progress Notes dated 8/28/25, showed at 1450 hours, a resident was heard yelling nurse. The nurse was notified of someone was screaming help at the patio outside of the resident's room. The note further showed Resident 1 was noted lying on his left side with a cut in the forehead and multiple cuts and scrapes on the arms and legs. Review of Resident 1's SBAR Summary for Providers dated 8/28/25, showed the resident had a fall and the physician had ordered for the resident to be transferred to the acute care hospital. Review of Resident 1's IDT dated 8/29/25, showed Resident 1 had a fall on 8/28/25. The note showed prior to the incident, the resident had been wheeling self independently with constant supervision by nursing staff. The resident was last seen by the CNA and LVN by the nurse's station at around1440 hours. The note further showed the resident continued to wheel self and constant redirection had been offered to the resident, but had not been easily redirected. On 9/25/25 at 1315 hours, an interview and concurrent medical review was conducted with RN 2. RN 2 stated Resident 1 was a wanderer. Resident 1 would wheel himself everywhere inside the facility and sometimes from room to room. When asked for how long Resident 1 was in the patio, RN 2 was not able to determine. RN 2 acknowledged the resident's whereabouts were not monitored. On 9/25/25 at 1430 hours, an interview and concurrent medical review was conducted with the ADON/IP. The ADON/IP stated the resident would wheel self constantly and goes from room to room. The facility staff would always redirect Resident 1 and the resident would stop but would then continue to wheel himself aimlessly. When asked where did the CNA last saw Resident 1, the ADON/IP was unable to provide the information. The ADON/IP verified Resident 1 was alone and unsupervised in the patio when the fall incident happened. On 9/25/25 at 1615 hours, the Administrator and DON was made aware and acknowledged the above findings.