

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055996	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Covenant Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3408 East Shields Avenue Fresno, CA 93726	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</p> <p>Based on observation, interview and record review, the facility failed to ensure licensed nurses (LN) administered medications in accordance with professional standards of practice for one of seven sampled residents (Resident 5), when:</p> <ol style="list-style-type: none"> 1. Resident 5's morning medications were left at the bedside unattended and not administered as prescribed by the physician on 9/16/24. <p>This failure resulted in Resident 5 not receiving the medications as prescribed by the physician, which had the placed Resident 5 at risk for thrombosis (clotting of the blood), embolism (obstruction or blockage in a blood vessel) and had the potential for other facility residents to ingest the medications that were left unattended.</p> <ol style="list-style-type: none"> 2. One of Two Licensed Nurses failed to lock the medication cart when the cart was out of the nurse ' s sight, according to the facility ' s policy and procedure (P&P). <p>This failure had the potential for staff, visitors, or residents to access medications from the unlocked medication cart.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/16/24 at 12:09 p.m. with Resident 5, in Resident 5 ' s room, a small, clear plastic cup was on Resident 5 ' s bedside table and contained four medications, a round white tablet, a round dark red tablet, a small yellow tablet, and a dark capsule. Resident 5 stated the nurse brought his medication in around 9:00 a.m. and left them on the table so he could take them later. Resident 5 stated he usually preferred to take his morning medication around lunchtime.</p> <p>During a review of Resident 5 ' s Admission Record, undated, the admission record indicated, Resident 5 was admitted to the facility on [DATE] with diagnosis of paraplegia (paralysis [loss of ability to move] of the legs and lower body), malignant neoplasm of the right testis (cancer in the testicle), malignant neoplasm of spinal cord (cancer spread to the spine [backbone]) and acute (sudden onset) embolism and thrombosis of the iliac vein (blood vessel in the pelvis).</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Residents 5 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 5 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 5 was cognitively intact.</p> <p>During a concurrent observation and interview on 9/16/24 at 12:12 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 5 ' s room, the cup of medication was observed on Resident 5 ' s bedside table. LVN 1 stated the medication was apixaban (medication to treat blood clots), magnesium (dietary supplement), multiple vitamin (dietary supplement), and vitamin D (dietary supplement). LVN 1 stated, I shouldn ' t have done that [left medication at bedside]. LVN 1 stated Resident 5 did not want to take his medication during the 8:00 a.m. medication pass, so she left the medication on his table. LVN 1 stated medication should never be left at bedside because there was no way to be sure the resident took the medication. LVN 1 stated medications left at bedside placed other residents at risk because they could wander in and take medication not prescribed to them. LVN 1 stated apixaban was a blood thinner and could place a resident at risk for bruising and bleeding if they it was not prescribed to them.</p> <p>During a concurrent interview and record review on 9/16/24 at 12:35 p.m. with LVN 2, Resident 5 ' s Order Summary Report, (OSR), dated September 2024 were reviewed. The OSR indicated, . [brand name for apixaban] Oral Tablet 2.5 mg [milligrams-unit of measurement] (Apixaban) Give 1 tablet by mouth two times a day . Magnesium Oxide Oral Tablet 400 mg (Magnesium Oxide) Give 1 tablet by mouth three times a day . Multiple Vitamin Tablet Give 1 tablet by mouth one time a day . Ergocalciferol [a form of vitamin D] Oral Capsule 1.25 MG . Give 1 capsule by mouth one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for vitamin D supplement . LVN 2 stated the medication should have been consumed within an hour of the scheduled 8:00 a.m. medication time. LVN 2 stated it was not safe to leave a medication unattended at bedside because another resident could consume the medication. LVN 2 stated if a resident took a blood thinner not prescribed to them it could cause bleeding.</p> <p>During an interview on 9/16/24 at 12:50 p.m. with LVN 3, LVN 3 stated another resident could have taken the medication left at bedside. LVN 3 stated it could cause adverse side effects and there would be no way to know if the resident took the medication which could affect the therapeutic level (maintain a certain level in the blood to work properly) if it is a medication needing a consistent blood level.</p> <p>During a review of the facility ' s P&P titled Administering Medications, dated 4/2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any required time frame . Medications are administered within one (1) hour of their prescribed time . Residents may self-administer their own medication only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview and P&P review on 9/24/24 at 3:32 p.m., with the Director of Nursing (DON), the DON stated medication should never be left at bedside. The DON stated if a resident wanted to self-administer medication there was a process to follow including an assessment, care plan and a doctor ' s order. The DON stated Resident 5 had not been assessed for self-administration and the medication should not have been left. The DON stated Resident 5 was on a blood thinner, so it was important for the nurse to verify he had taken the medication. The DON stated it was a safety issue if a resident with dementia had wandered in the room and taken the medication. The DON stated the P&P was to administer a medication within an hour of the scheduled time and the P&P was not followed.</p> <p>During a professional reference review of Lippincott Manual of Nursing Practice 10th Edition, dated 2014, indicated, .Standards of Practice .General Principles .Common Departures from the Standards of Nursing Care .Legal claims most commonly made against professional nurses include the following departures from appropriate care .failure to .follow physician orders .adhere to facility policy or procedure .administer medications as ordered .</p> <p>2. During a concurrent observation and interview on 9/16/24 at 12:12 p.m. with LVN 1, the medication cart was observed with the lock pulled all the way out which indicated it was unlocked. LVN 1 took out the keys of her pocket and went to unlock the cart, did not put the key in the lock and placed the keys back into her pocket. LVN 1 stated, it [the medication cart] might have been left open. LVN 1 opened the drawer and took out the glucometer, then pushed the lock in locking the cart. LVN 1 stated the cart should be locked when she was not in front of the cart because anybody could access the medication.</p> <p>During an interview on 9/16/24 at 12:35 p.m. with LVN 2, LVN 2 stated she always locked the medication cart anytime she was not directly in front of it. LVN 2 stated the cart should never be unlocked if unattended. LVN 2 stated anyone including residents would be able to access the medication.</p> <p>During an interview on 9/16/24 at 12:50 p.m. with LVN 3, LVN 3 stated the medication cart needed to be locked anytime it was unattended. LVN 3 stated anybody could access the medication and narcotics were supposed to be kept under two locks, if one lock was undone the narcotics were not stored appropriately.</p> <p>During a telephone interview on 9/24/24 at 3:32 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the medication cart to be locked unless the nurse was actively working with it. The DON stated an unlocked medication cart was a safety issue because confused residents and visitors could access the medication. The DON stated it could also cause an issue with HIPPA (Health Insurance Portability and Accountability Act-a federal law that sets a national standard to protect medical records and other personal health information).</p> <p>During a review of the facility ' s P&P titled Administering Medications, dated 4/2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed . During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse . The cart must be clearly visible to the personnel administering medications .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a professional reference retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/lewingroup.pdf, titled, CMS Review of Current Standards of Practice for Long-Term Care Pharmacy Services Long-Term Care Pharmacy Primer, dated December 30, 2004, the professional reference review indicated, .C. Administration of Medications by Nursing Facility Personnel . Nursing facility personnel administer medications pursuant to the prescription order. The personnel designated to administer medications must be trained by the nursing facility . Medication Carts . The carts contain locked, non-removable drawers for each resident's medications . Medication carts must be supervised at all times by the nurse administering medications. When medication carts are not in use, they must be stored in a designated locked area with all drawers locked .</p>