

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 03/18/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42123</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment for one of five sampled residents (Resident 1) when the facility ' s boiler system (a system of vessels and tubes, in which water is heated) was not functional, Certified Nursing Assistant (CNA) 2 gave Resident 1 a bed bath with cold water.</p> <p>This failure violated Resident 1 ' s right to a homelike environment and caused him to feel uncomfortable and chilled during the bed bath.</p> <p>Findings:</p> <p>During an interview on 3/18/25 at 10:00 a.m. with the Administrator (ADM), the ADM stated he received a phone call from the Director of Maintenance (DOM) on the morning of 3/18/25 because the boiler to the facility ' s water supply was not working. The ADM stated the Vendor (VDR) came out and replaced the ignition control module (electronic panel that manages the ignition process, ensuring the boiler is lit safely) on the boiler but discovered a gas valve (essential to control the flow of gas to the boiler) had also failed. The VDR did not have the gas valve in stock and could not order it until Monday 3/17/25.</p> <p>During an interview on 3/18/25 at 10:29 a.m. with Resident 1, Resident 1 stated he was notified there was no hot water on Saturday (3/15/25). Resident 1 stated his scheduled shower days were Tuesdays and Fridays. Resident 1 stated he was given a bed bath earlier in the day and the CNA had not been notified there was an alternate source to get hot water for a bed bath. Resident 1 stated, she gave me a cold bed bath. It was like biting a bullet. Resident 1 stated he was expecting warm water, then was washed with cold water which gave him chills throughout the bed bath and was not a thorough cleaning.</p> <p>During a concurrent observation and interview on 3/18/25 at 11:22 a.m., the sink temperature in Resident 1 ' s room was measured and registered 65.8 degrees () Fahrenheit (F- a unit of temperature measurement- 212 F is boiling, and 32 F is freezing).</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25 at 11:54 a.m. with CNA 2, CNA 2 stated she was assigned to Resident 1. CNA 2 stated when she arrived at work, she was notified the boiler was not working, so there was no hot water. CNA 2 stated she gave Resident 1 a cold bed bath because she was not aware there was an alternate source for hot water available in the breakroom. CNA 2 stated, I felt so bad. CNA 2 stated Resident 1 was chilled and asked her during the bed bath when the facility would have hot water again. CNA 2 stated she should have used warm water for Resident 1 ' s bed bath.</p> <p>During an interview on 3/18/25 at 1:41 p.m. with CNA 3, CNA 3 stated he used hot water from the dispenser in the breakroom for resident bed baths. CNA 3 stated it was important to use warm water when providing a bed bath to make sure the resident was comfortable.</p> <p>During an interview on 3/18/25 at 1:47 p.m. with the Director of Staff Development (DSD), the DSD stated the hot water heater stopped working on Saturday 3/15/25. The DSD stated she and the Director of Nursing (DON) provided in-services to the staff over the weekend regarding the alternate hot water source and hand hygiene. The DSD stated the CNAs were offering the residents bed baths since there was no hot water for showering. The DSD stated the CNAs were instructed to use the hot water available in the breakroom for bed baths. The DSD stated the expectation for bed baths was for the CNA to test the water temperature themselves and have the resident check the water temperature before giving the resident a bed bath because it was important to make sure the resident was comfortable. The DSD stated a resident should not have a bed bath with cold water because it could be a shock to the resident ' s system and the residents would become easily chilled because their body temperature was not always functioning correctly due to chronic illnesses. The DSD stated, they [the CNAs] would not take a cold bath themselves.</p> <p>During an interview on 3/18/25 at 1:54 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the staff received texts over the weekend notifying them the facility did not have hot water. LVN 1 stated the staff were instructed there was a hot water source from a dispenser in the breakroom to use for resident baths.</p> <p>During an interview on 3/18/25 at 2:28 p.m. with the DON, the DON stated she and the DSD had been giving the staff in-services and instructed the staff to use the hot water dispenser in the breakroom for resident bed baths. The DON stated her expectation was for the staff to use warm water at the resident ' s preferred temperature for bed baths. The DON stated the residents should not receive a cold bed bath because they were at higher risk for hypothermia (a significant and dangerous drop body temperature) due to their age or health conditions.</p> <p>During an interview on 3/18/25 at 2:45 p.m. with the ADM, the ADM stated the expectations for bed baths was for the staff to provide warm water to fill the basin. The ADM stated the water temperature should be checked on the arm prior to bathing the resident and he would hope a resident did not have a cold bed bath.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Bed Baths, dated 9/2/22, the P&P indicated, . It is the practice of this facility to assist residents with bed bathing to maintain proper hygiene and prevent skin issues . Fill the basin halfway with warm water to the touch (between 98.6 F to 103 F). Have the resident feel the water to ensure it is comfortable for them .</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s P&P titled Resident Rights, dated 2/2021, the P&P indicated, . Employees shall treat all residents with kindness, respect, and dignity . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to . a dignified existence . be treated with respect, kindness, and dignity . self-determination .</p> <p>During a review of the facility ' s P&P titled Homelike Environment, dated 2/2021, the P&P indicated, . Residents are provided with a safe, clean, comfortable and homelike environment . Staff provides person-centered care that emphasizes the residents ' comfort, independence and personal needs and preferences .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42123</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when one of two facility boiler systems (a device that heats the facility ' s water and/or ventilation system) stopped working and the laundry was washed in temperatures below the minimum water temperatures according to the facility ' s policy and procedure (P&P).</p> <p>This failure placed the 117 residents at risk for cross contamination from laundry not properly washed and sanitized according to the P&P.</p> <p>Findings:</p> <p>During an interview on 3/18/25 at 10:00 a.m. with the Administrator (ADM), the ADM stated he received a phone call from the Director of Maintenance (DOM) on the morning of 3/18/25 because the boiler to the facility ' s water supply was not working. The ADM stated the Vendor (VDR) came out and replaced the ignition control module (electronic panel that manages the ignition process, ensuring the boiler is lit safely) on the boiler but discovered a gas valve (essential to control the flow of gas to the boiler) had also failed. The VDR did not have the gas valve in stock and could not order it until Monday 3/17/25.</p> <p>During a concurrent observation and interview on 3/18/25 at 10:15 a.m. with Laundry Aide (LA) 1, LA 1 was in the clean linen area folding clothes. LA 1 stated when she came to work on 3/17/25, she was notified there was no hot water. LA 1 stated she washed the clothing and linens in cold water since no hot water was available.</p> <p>During a concurrent observation and interview on 3/18/25 at 10:20 a.m., with the Housekeeping Supervisor (HKS), the HKS stated she was also the supervisor for laundry. The HKS stated the facility washed clothing and linens in chemicals designed for low temperature washing. The HKS reviewed the laundry detergent label and stated it could be used at low temperatures, the recommended temperature was 130 degrees () Fahrenheit (F-unit of temperature measurement on which water freezes at 32 and boils at 212) to 150 F. The HKS stated the temperature was only recommended. There was a chemical dispenser on the wall next to the washers, the HKS stated it housed chlorine bleach, detergent and laundry sanitizer. The HKS stated the chemicals were automatically mixed to the wash by the dispenser. The HKS stated only white linens used bleach.</p> <p>During a concurrent observation and interview on 3/18/25 at 11:22 a.m. with the DOM, the laundry room sink water temperature was tested at 66.9 F. The DOM stated sink ' s water temperatures should be approximately 105 deg F. The DOM stated the water temperature in the washing machine would be the same as the sink because they were on the same water line.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on 3/18/25 at 1:30 p.m. with the HKS, the facility ' s policy and procedure (P&P) titled, Departmental (Environmental Services)-Laundry and Linen, dated 1/2014 was reviewed. The P&P indicated, . Washing Linen and other Soiled Items . Laundry may be processed in either low-temperature or high-temperature cycles . For low-temperature processing, wash linen in water that is at least 71-77 F and use a . chlorine bleach rinse if the material can withstand bleach and remain intact . The HKS stated she was unsure if 66.9 F met the facility ' s P&P of 71-77 F. The HKS stated the DOM would be in charge of the water temperatures. The HKS stated there was no way to know if the washer water met the minimum temperature according to the facility P&P. The HKS stated the facility used chlorine bleach only for the whites and linens, but not on the colored laundry.</p> <p>During an interview on 3/18/25 at 1:33 p.m. with the DOM, the DOM stated he did not deal with laundry, and it would be up to the HKS to know if the laundry temperature P&P was followed.</p> <p>During a concurrent interview and record review on 3/18/25 at 2:28 p.m. with the Director of Nursing (DON), the DON stated the Infection Preventionist was on vacation. The DON stated the IP would usually oversee the infection prevention practices of the laundry department. The DON reviewed the facility ' s P&P titled Departmental (Environmental Services)-Laundry and Linen, and stated the P&P indicated for low temperature wash, the laundry should be washed at a minimum temperature of 71-77 F. The DON stated if the water temperature was below the 71 F, it did not follow the P&P.</p> <p>During an interview on 3/18/25 at 2:45 p.m. with the ADM, the ADM stated when the IP was off, the DSD would normally take her place. The ADM reviewed the P&P for laundry and stated he would have to check the water temperature in the laundry room to see if the 71-77 F was met. The ADM stated if the laundry room water temperature was in the 60 ' s then the policy was not followed.</p> <p>During a review of a professional reference found at</p> <p>https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html#:~:text=Several%20studies%20have%20demonstrated%20that,are%20carefully%20monitored%20and%20controlled. Titled G. Laundry and Bedding, dated 2003, the reference indicated, . Laundry in a health-care facility may include bed sheets and blankets, towels, personal clothing, patient apparel . Several studies have demonstrated that lower water temperatures of 71 F-77 F . can reduce microbial contamination when the cycling of the washer, the wash detergent, and the amount of laundry additive are carefully monitored and controlled .</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</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 maintain essential equipment in a safe operating condition when one of two boiler systems (a device that heats the facility ' s water and/or ventilation system) was not monitored, maintained and failed to operate from 3/15/25 to 3/18/25.</p> <p>This failure resulted in a non-functioning boiler system, unable to heat water throughout the facility including the laundry, kitchen, showers and sink faucets and placed the residents at risk for poor hygiene, infectious disease and discomfort. The facility ' s residents were unable to shower for three days, had to eat with disposable flatware and Styrofoam trays, and clothing and linens were washed in subpar (below normal) temperatures according to the facility policy and procedure (P&P). (cross reference F880, F584)</p> <p>Findings:</p> <p>During an interview on 3/18/25 at 10:00 a.m. with the Administrator (ADM), the ADM stated he received a phone call from the Director of Maintenance (DOM) on the morning of 3/18/25 because the boiler to the facility ' s water supply was not working. The ADM stated the Vendor (VDR) came out and replaced the ignition control module (electronic panel that manages the ignition process, ensuring the boiler is lit safely) on the boiler but discovered a gas valve (essential to control the flow of gas to the boiler) had also failed. The VDR did not have the gas valve in stock and could not order it until Monday 3/17/25.</p> <p>During a concurrent observation and interview on 3/18/25 at 10:15 a.m. with Laundry Aide (LA) 1, LA 1 was in the clean linen area folding clothes. LA 1 stated when she came to work on 3/17/25, she was notified there was no hot water. LA 1 stated she washed the clothing and linens in cold water since no hot water was available.</p> <p>During a concurrent observation and interview on 3/18/25 at 10:20 a.m., with the Housekeeping Supervisor (HKS), the HKS stated she was also the supervisor for laundry. The HKS stated the facility washed clothing and linens in chemicals designed for low temperature washing. The HKS reviewed the laundry detergent label and stated it could be used at low temperatures, the recommended temperature was 130 degrees () Fahrenheit (F-unit of temperature measurement on which water freezes at 32 and boils at 212) to 150 F. The HKS stated the temperature was only recommended. There was a chemical dispenser on the wall next to the washers, the HKS stated it housed chlorine bleach, detergent and laundry sanitizer. The HKS stated the chemicals were automatically mixed to the wash by the dispenser. The HKS stated only white linens used bleach.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/18/25 at 10:29 a.m. with Resident 1, Resident 1 stated he was notified there was no hot water on Saturday (3/15/25). Resident 1 stated his scheduled shower days were Tuesdays and Fridays. Resident 1 stated he showered on Friday (3/14/25) and the facility had hot water at that time. Resident 1 stated he was given a bed bath earlier in the day and the CNA had not been notified there was an alternate source to get hot water for a bed bath. Resident 1 stated, she gave me a cold bed bath. It was like biting a bullet. Resident 1 stated he was expecting warm water, then was washed with cold water which gave him chills throughout the bed bath and was not a thorough cleaning. Resident 1 stated because there was no hot water to wash dishes, the meals were coming in Styrofoam containers with disposable utensils.</p> <p>During an interview on 3/18/25 at 10:35 a.m. Resident 2 stated his shower days were Saturdays and Wednesdays. Resident 2 stated he did not receive a shower or a bed bath on Saturday (3/15/25). Resident 2 stated he did not want a bed bath and had not bathed for 6 days.</p> <p>During an interview on 3/18/25 at 10:37 a.m. with Resident 3, Resident 3 stated he was scheduled for showers on Wednesdays and Saturdays. Resident 3 stated he did not receive a shower or bed bath on 3/15/25 and washed himself using cold water in the sink.</p> <p>During an interview on 3/18/25 at 10:40 a.m. with Resident 4, Resident 4 stated he was not told about the hot water outage until he had washed his face and brushed his teeth with cold water on 3/15/25. Resident 4 stated he asked a CNA and was told the hot water was not working. Resident 4 stated his shower days were Wednesdays and Saturdays. Resident 4 stated on Saturday he just cleaned himself up with cold water and did not get a bed bath.</p> <p>During a concurrent observation and interview on 3/18/25 at 11:00 a.m. with the DOM, the facility ' s hot water boiler was observed and there was no heat coming from the boiler. The boiler for the facility ' s heater ventilation system was working and heat could be felt standing next to it, its thermometer read 160 F. The DOM stated the water boiler system supplied the entire facility ' s hot water, and the module had stopped working on Saturday (3/15/25). The DOM stated the VDR came out and replaced the module but discovered gas valve was not working. The DOM stated the VDR did not provide routine maintenance to the boilers but would come out when there was a transition in season requiring a change between the air conditioner and heater. The DOM stated they call the VDR when there is issue, but no routine maintenance was scheduled.</p> <p>During a concurrent observation and interview on 3/18/25 at 11:05 a.m. with the DOM in the kitchen, there were three sinks observed, a dish washing sink, a hand washing sink and food preparation sink. The water temperatures were checked and indicated:</p> <p>Dish sink-61.7 deg F</p> <p>Food prep sink-64.6 deg F</p> <p>Hand wash sink-63.3 deg F</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/18/25 at 11:10 a.m. with [NAME] (CK) 1, CK 1 stated she used the hand washing sink with cold water and soap to clean her hands while working in the kitchen and would then use hand sanitizer to ensure she had clean hands. CK 1 stated the dishwasher was still able to reach the correct temperature for sanitizing dishes, so they were able to wash the items they cooked with in hot water. CK 1 stated there was a dispenser for hot water which they used to make coffee, and they used the hot water from there for any needs for hot water such as dish washing by hand and the sanitation bucket. CK 1 stated their hands and dishes had to be sanitized correctly and if they were not then, that is bad for residents, they could get sick from the food. CK 1 stated the lack of hot water placed the resident ' s food at risk for cross contamination.</p> <p>During an interview on 3/18/25 at 11:15 a.m. with CK 2, CK 2 stated he washed his hands in cold water and soap then used gloves while cooking. CK 2 stated it was important to sanitize hands and dishes to prevent food borne illness (illness that comes from eating contaminated food).</p> <p>During an interview on 3/18/25 11:20 a.m. with Resident 5, Resident 5 stated he had been washing his hands in cold water. Resident 5 stated he was a new admit and was not notified the facility did not have hot water.</p> <p>During a concurrent observation and interview on 3/18/25 at 11:22 a.m. with the DOM, the sink temperature in Resident 5 ' s room was checked. The temperature read 64.8. The DOM stated the sink temperatures should be approximately 105 deg F. Several water temperatures were checked throughout the facility as follows:</p> <p>room [ROOM NUMBER]-bathroom sink- 65.8 F</p> <p>Station 2 shower- 64.9 F</p> <p>Station 1 shower- 66.0 F</p> <p>Station 4 shower 66.4 F</p> <p>Station 3 shower 60.4 F</p> <p>room [ROOM NUMBER]-bathroom sink-65.8 F</p> <p>room [ROOM NUMBER]-bathroom sink-65.8 F</p> <p>Laundry room sink- 66.9 F</p> <p>The DOM stated the water temperature, and the washing machine water temperature would be the same (66.9) because they were on the same water line.</p> <p>During an interview on 3/18/25 at 11:48 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated when she worked on Sunday, she was told the water heater was not working. CNA 1 stated they were instructed there was a hot water dispenser in the breakroom to get water for bed baths. CNA 1 stated they were using hand wipes to clean the residents ' hands as needed and before meals.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/18/25 at 11:54 a.m. with CNA 2, CNA 2 stated she was assigned to Resident 1. CNA 2 stated when she arrived at work, she was notified the boiler was not working, so there was no hot water. CNA 2 stated she gave Resident 1 a cold bed bath because she was not aware there was an alternate source for hot water available in the breakroom. CNA 2 stated, I felt so bad. CNA 2 stated Resident 1 was chilled and asked her during the bed bath when the facility would have hot water again. CNA 2 stated she should have used warm water for Resident 1 ' s bed bath.</p> <p>During a telephone interview on 3/18/25 at 2:06 p.m. with the VDR, the VDR stated they were called out on Saturday 3/15/25 because the water heater boiler was not working. The VDR stated he sent a technician out to fix the problem. The VDR stated the ignition control module was replaced, and it was then discovered the gas valve was not functioning. The VDR stated the module was the brains of the system and the gas valve was controlled by the module. The VDR stated both parts had to work together for the boiler to work correctly. The VDR stated the company was not scheduled for routine, preventative maintenance of the boiler and were only called out for emergencies and twice a year when contacted, to switch the heater to air conditioning and the air conditioning back to the heater as the weather changed.</p> <p>During a review of the Vendor ' s invoice to the facility dated 3/17/25, the invoice indicated, . pressure regulating gas V [valve-device for controlling passage] . Quantity 1 . IGN [ignition-firing something up] Module . Quantity 1 .</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Maintenance Service, dated 12/2009, the P&P indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment . Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order . Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner .</p> <p>During a review of the facility ' s P&P titled Unusual Occurrence Reporting, dated 12/2007, the P&P indicated, . our facility reports unusual occurrences or other reportable events which affect the heath, safety, or welfare of our residents, employees or visitors . Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors .</p>		