STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055996	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Post Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to report an injury of unknown origin (any injury without a reason the injury could have or did occur) in accordance with their abuse policy and procedure (P&P) for one of three sampled residents (Resident 1) when Resident 1 was found with discoloration (a different color than normal) around his right eye on 4/12/25 and the injury was not reported to the California Department of Public Health (CDPH) and adult protective services until 4/14/25. This failure led to the delay of the investigation into the cause of Resident 1 ' s injury to rule out the potential for abuse. Findings: During an interview on 4/30/25 at 1:29 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had Huntington ' s Disease (causes nerve cells in the brain to decay over time affecting a person ' s movements, thinking ability and mental health) with involuntary body movement (abnormal, random muscle movements) and confused at times. During an observation on 4/30/25 at 1:43 p.m., Resident 1 was groomed and dressed sitting in a wheelchair in his room. Resident 1 had involuntary movements in his body, head, arms and legs. Resident 1 was asked if he remembered what happened to his eye and appeared to shake his head no. Resident 1 attempted to speak but his words were not clear. During a review of Resident 1 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including Huntington ' s Disease and dementia (decline in thinking, memory and reasoning). During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 04 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 1 had a severe 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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 1:57 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 had a black eye (bruise caused by a collection of blood under the skin) a couple of weeks ago. CNA 1 stated she had asked Resident 1 what happened to his eye, and he laughed. CNA 1 stated Resident 1 was on every 15-minute checks by staff before the black eye happened. CNA 1 stated a black eye could be a potential sign of abuse and needed to be reported to the charge nurse and Administrator (ADM) as soon as possible. During an interview on 4/30/25 at 2:28 p.m. with CNA 2, CNA 2 stated he frequently took care of Resident 1. CNA 2 stated when he started his shift on 4/12/25 at 6:30 a.m., he found Resident 1 with a black eye. CNA 2 stated he thought another CNA had reported the black eye to the charge nurse, so he did not tell the nurse himself. During a concurrent interview and record review on 4/30/25 at 2:34 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/12/25 around 8:00 a.m., LVN 2 notified her Resident 1 had discoloration around his right eye. LVN 1 stated LVN 2 had administered Resident 1 ' s morning medication and discovered the skin around his eye was discolored. Resident 1 ' s Progress Note, dated 4/12/25 at 10:05 a.m. was reviewed. The note indicated, During med pass, writer noted that resident has a black eye around right eye. The resident stated he doesn ' t know how he got the black eye .There were no reports of falls or accidents in the recent past that could explain the injury . LVN 1 stated the ADM was the facility ' s abuse coordinator and he should have been notified immediately because an unwitnessed injury of a bruised, discolored eye could indicate abuse. LVN 1 stated LVN 2 had notified the DON but was unable to locate documentation indicating when the DON was notified. LVN 1 was unable to locate documentation indicating the ADM had been notified. Resident 1 ' s IDT (Interdisciplinary team- team from different healthcare disciplines who work together to provide compressive patient care) note dated 4/14/25 at 12:39 p.m. was reviewed, the note indicated, . Resident was observed with red and blue discoloration around the right eye. No evidence of fall, physical altercation, or abuse was found . Per staff he was agitated on Friday [4/11/25] in dining room, he was redirected to his room until he was calm. Per staff interview there was no physical contact made with resident at that time . LVN 1 stated she had asked Resident 1 how he got the black eye, and he was unable to state how it happened. LVN 1 stated she had not suspected abuse, but the incident was unwitnessed, and Resident 1 was not able to report what happened, so it should have been treated as abuse. During an interview on 4/30/25 at 2:55 p.m. with LVN 2, LVN 2 stated she was Resident 1 ' s nurse on 4/12/25 and had gone into Resident 1 ' s room between 8:30 and 9:00 a.m. to administer his medications and noticed the discoloration around his eye. LVN 2 stated she had finished passing the other resident ' s medications before she notified the DON around 10:00 a.m. LVN 2 stated she did not notify the ADM. LVN 2 was unable to state who the facility ' s abuse coordinator was. LVN 2 was unable to locate documentation indicating she had notified the DON of Resident 1 ' s discolored eye. LVN 2 stated she did not call the police department, but she should have since a black eye could be a sign or abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 3:05 p.m. with the DON, the DON stated LVN 2 had notified her immediately after Resident 1 ' s discolored eye was found, receiving the call around 10:00 a.m. The DON stated she thought the ADM had reported the incident to the police department but was unable to provide supporting documentation. The DON stated suspected abuse needed to be reported within two hours to the abuse coordinator and 24 hours to CDPH. The DON stated Resident 1 had been on 15-minute checks at the time of the discolored eye and she was unsure why the staff had not noticed his eye sooner. The DON stated there was no documentation in the electronic medical record indicating when the state licensing agency or ombudsman were notified. The DON stated she was unsure if the ADM had reported the incident to law enforcement. The DON stated Resident 1 ' s discolored eye could have been the result of abuse, but the IDT did not suspect abuse had caused it. During a concurrent telephone interview and P&P review on 5/5/25 at 9:55 a.m. with the ADM, the ADM stated he had a copy of the facility ' s abuse P&P. The facility ' s P&P titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 4/2021, was reviewed and indicated, . If resident abuse . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . The ADM stated Resident 1 ' s discolored eye was an injury of unknown source because it was unwitnessed, and the resident could not state what happened. The ADM stated he notified the state licensing agency and ombudsman by fax on 4/14/25. The ADM stated the P&P indicated suspicion of abuse should have been reported within two hours according to the facility ' s P&P. The ADM stated the P&P was not followed. During a telephone interview with the Ombudsman (OMB-advocate who works to ensure the health, safety and well-being of nursing home residents), the OMB stated they received the report of Resident 1 ' s injury on 4/15/25. During a review of an e-mail provided by the ADM, indicated he sent the report regarding Resident 1 ' s injury to CDPH on 4/14/25 at 4:03 p.m. During a review of the State Operations Manual, dated 8/8/2024, the SOM indicated, . Injuries of unknown source-An injury should be classified as an injury of unknown source when all of the following criteria are met . source of injury was not observed by any person . source of injury could not be explained by the resident . injury is suspicious because of the extent of the injury or location of the injury . During a review of the facility ' s P&P titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 4/2021, . All reports of resident abuse (including injuries of unknow origin) . are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management . If resident abuse . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . administrator or the individual making the allegation immediately . to the following persons or agencies . state licensing/certification agency responsible for surveying/licensing the facility . local/state ombudsman . Law enforcement officials . Immediately is defined as . within two hours of an allegation involving abuse .