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	01/07/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided for one of three sampled residents (Resident 1) when Resident 1 was assessed as having physically aggressive behaviors towards other residents and staff, was supposed to be on one on one supervision (1:1-staff provide constant, close oversight for resident needing extra safety due to cognitive issues [problems with mental functions like thinking, learning, memory and judgment], behavioral problems [disruptive patterns of action or conduct] or potential self/other harm) monitoring when out of his room and on 12/23/25 the staff assigned to Resident 1 left the resident unattended in his room and Resident 1 left his room unnoticed.This failure resulted in Resident 1 hitting Resident 2 in the face, causing swelling and a scratch to the upper lip requiring first aid to the left upper lip and had the potential for Resident 2 sustaining significant injuries.During a concurrent observation and interview on 1/7/26 at 10:35 a.m. with Resident 2, Resident 2 was lying in bed, no swelling noted to his upper lip. Resident 2 stated he was a couple weeks previously he was sitting in his wheelchair across from the therapy room and Resident 1 came up from behind him standing very close to him so he asked him to back off and come around front so he could see him. Resident 2 stated he turned his wheelchair around and Resident 1 punched him in the mouth. Resident 2 stated his lip split open and swelled up after Resident 1 hit him. Resident 2 motioned his hand to the left side of his lips and said the hit caused him to bleed. Resident 2 stated it surprised him more than causing pain. Resident 2 stated there was no staff with Resident 1 at the time of the incident. Resident 2 stated the Administrator (ADM) was walking by when the incident happened, came over and broke up the fight.During a review of Resident 2's admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (infection of the bone), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control), acquired absence of right leg below knee (amputation due to surgery, accident or severe injury), and acquired absence of left leg below knee.During a review of Residents 2's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2'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 2 was cognitively intact.During a review of Resident 2's Progress Note, dated 12/23/25, the progress note indicated, . Resident was victim of res to res altercation with another resident at approximately 1237 pm in front of the therapy by the front window. Resident [1] approach resident [2] while he was sitting in front window and started yelling at him. resident stated, He approached me from behind I turned my neck back and told him don't walk up from behind I don't know you like that. Res [1] started punching Res [2]. Both residents were punching.During a review of Resident (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2's SBAR, dated 12/23/25, the SBAR, indicated, . Resident was victim of res to res altercation. Resident has a scratch to top left side of lip with swelling noted. NP [nurse practitioner-name of provider] in house gave new order. Cleanse scratch to top left side of lip with NS [normal saline], pat dry, apply pea size amount of triple antibiotic ointment, leave open to air.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 muscle wasting and atrophy (muscles shrink and become weaker), Type 2 diabetes mellitus, dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), alcohol abuse and anxiety disorders (feelings of fear, dread or apprehension).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 03 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 severe cognitive impairment.During an interview on 1/7/26 at 11:10 a.m. with the ADM, the ADM stated Resident 1 had a history of post-traumatic stress disorder (PTSD) and had unprompted outbursts. The ADM stated he had watched a video of the altercation and it appeared resident 1 came in close proximity to Resident 2, when Resident 2 turned his wheelchair around, Resident 1 saw it as a threat and hit him. The ADM stated the altercation was unprompted and Resident 1 had a history of resident-to-resident altercations. The ADM stated he happened to be in the hallway at the time and separated the residents. The ADM stated Resident 1 was on a 1:1.During an interview on 1/7/26 at 12:04 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Residents 1 and 2. CNA 1 stated Resident 1 was known to have violent behavior towards others and was unpredictable. CNA 1 stated Resident 1's behavior would change quickly making it hard to predict. CNA 1 stated Resident 1 had been on a 1:1 prior to the incident.During an interview on 1/7/26 at 12:20 p.m. with CNA 2, CNA 2 stated she had taken care of Resident 1 several times. CNA 2 stated Resident 1 would get aggressive and strike out at times. CNA 2 stated Resident 1's demeanor would change quickly and the staff knew to step back away from him because he would hit. CNA 2 stated on the day of the altercation with Residents 1 and 2, Resident 1 had been napping right before the incident. He left the room and went to Resident 2 and hit him. CNA 2 stated Resident 1 was on 1:1 while he was having his episodes and when out of his room. CNA 2 stated Resident 1 had been left alone because he was asleep in his room prior to the incident. CNA 2 stated Resident 1 needed a staff member to stay with him for safety because nobody would know when he would wake up aggressive. CNA 2 stated on the day of the incident the night shift told the day shift in report Resident 1 had woken up mad. CNA 2 stated Resident 1 had a history of altercations with other residents.During a concurrent interview and record review on 1/7/26 at 12:40 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she usually took care of Resident 1 but was off the day of the altercation with Resident 2. LVN 1 stated Resident 1 was confused and had a history of altercations with other residents. Resident 1's altercation care plan dated 12/23/25 was reviewed. The Care plan indicated, . peer to peer altercation. Continue 1:1 when outside the room. Resident remains in private room. Staff continue to monitor from a respectful distance to minimize agitation as resident does not like staff walking next to him. LVN 1 stated Resident 1 had a verbal altercation with another resident earlier in the month and was supposed to have 1:1 supervision when he was out of his room. LVN 1 stated she was not sure why Resident 1 did not have a staff member with him during the altercation with Resident 2. During a telephone interview on 1/7/26 at 4:53 p.m. with LVN 2, LVN 2 stated she was familiar with Residents 1 and 2. LVN 2 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 would suddenly become very violent and hit staff. LVN 2 stated the staff would have to stay a safe distance from Resident 1 because his behavior was unpredictable. LVN 2 stated Resident 1 required a 1:1 for safety, but the staff had to follow safely behind him because he would get agitated if they walked with him. LVN 2 stated it was difficult to prevent Resident 1 from having altercations with other residents.During a telephone interview on 1/8/26 at 3:39 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was on a 1:1 while out of his room prior to the altercation on 12/23/25. The DON stated at the time a new CNA was assigned to Resident 1 for 1:1 supervision, but she did not stay with the resident. The DON stated the meal trays had come out and the CNA stepped away to help pass the trays leaving Resident 1 unattended. The DON stated if the CNA had stayed with Resident 1 she should have been able to prevent the altercation. The DON stated Resident 1 had frequent mood changes and a history of hitting other residents and staff. The DON stated she, the ADM, social services and rehabilitation staff heard the noise from the altercation in the hallway and went in to intervene.During a review of Resident 1's SBAR Communication Form, dated 12/23/25, the SBAR indicated, . Res/Res altercation punch another resident's face. started on: 12/23/2025. This condition, symptom, or sign has occurred before. yes. Treatment for last episode 1:1 supervision. Appearance. Resident was agitated this morning, pacing/yelling and cussing at staff and peers. Recommendations of Primary Clinicians. Monitor for aggressive behavior towards peers 1:1 supervision.During a review of Resident 1's Progress Note, dated 12/23/25, the note indicated, . At approximately 1237, the writer heard raised voices and yelling coming from the hallway near the large glass window. Observedthe resident striking peer resident. in the facial area. At the time of the incident, the resident was on one-to-one supervision. Supervision coverage and staff assignment were reviewed. Education and reinforcement were provided to assigned staff regarding continuous supervision requirements, including that residents on one-to-one supervision are not to be left unattended.During a review of Resident 1's note titled IDT (Interdisciplinary team- team from different healthcare disciplines who work together to provide comprehensive patient care), the note indicated, . Resident-to-Resident . Physical Altercation. Aggressor IDT Follow-Up. Incident. involved in resident-to-resident . physical altercation. Significant cognitive impairment BIMS 3 with poor safety awareness; partial recall of incident. History of repeated resident-to-resident aggression. IDT Determination. Based on repeated aggressive behaviors, prior history, and recent incident, the IDT determined that additional and escalated interventions are necessary to ensure the safety of the resident, peers, and staff. Current strategies require reinforcement and expansion to address. behavioral and supervision needs. Maintain continuous one-to-one supervision with uninterrupted visual monitoring. Protection of Others. Physical separation from vulnerable residents maintained. behaviors monitored and documented each shift. One-to-one supervision expectations reinforced with staff.During a review of Resident 1's behavior care plan dated 7/14/25, the care plan indicated, . altered behavior with potential to disrupt resident and/or others M/B [manifested by]: Verbal Aggression (screaming, cursing, threatening) Physical Aggression (punching, pushing, grabbing). Interventions. When resident ambulate[s] throughout the facility, a designated staff member will remain in close proximity, following at a safe distance, to provide immediate redirection if needed and to ensure that other residents are not placed at risk. Staff will maintain visual monitoring and safe positioning at all times, staying close enough to intervene promptly but not in a way that increases agitation. Date initiated: 08/23/2025. During a telephone interview on 1/13/26 at 10:07 a.m. with the Social Services Director (SSD), the SSD stated Resident 1 had a history of altercations with other residents and had behaviors or punching at people. The SSD stated the altercation between Residents 1 and 2 on 12/23/25 was the first time another (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was injured. The SSD stated at the time of the incident, Resident 1 was supposed to have 1:1 supervision when out of his room, but the assigned CNA left him alone to pass out meal trays. The SSD stated the CNA should not have left Resident 1 alone. The SSD stated Resident 1 had dementia but was physically able to walk and move quickly. The SSD stated on 12/23/25 she was in an office near where the altercation took place and heard a scream. The SSD stated she, the DON, the ADM and rehabilitation staff all ran to the scene, and she could see Resident 1 standing over Resident 2 who was in a wheelchair. The SSD stated after the incident she saw Resident 2 had a swollen lip.During a telephone interview on 1/13/26 at 2:24 p.m. with LVN 3, LVN 3 stated she was assigned to Resident 1 and was the charge nurse on 12/23/25 when the altercation took place. LVN 3 stated Resident 1 was extremely agitated when he woke up and she had administered his routine anti-anxiety medication which normally relieved his agitation and anxiety, but it was not effective that day. LVN 3 stated normally Resident 1 required 1:1 supervision when he left his room, but she was concerned about his behavior and assigned CNA 3 to stay with the resident throughout the shift. LVN 3 stated CNA 3 left to help pass meal trays at lunch and Resident 1 left his room undetected. LVN 3 stated CNA 3 should have stayed next to Resident 1's room to follow him when he left the room. LVN 3 stated she instructed CNA 3 that morning to quietly follow Resident 1 but to stay within proximity to prevent altercations.During a telephone interview on 1/13/26 at 3:57 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 had behaviors of being agitated and combative. The DSD stated CNA 3 was new and still on orientation at the time of the altercation on 12/23/25. The DSD stated she was unaware that LVN 3 assigned CNA 3 to do a 1:1 with Resident 1, so she had not provided CNA 3 education specific to Resident 1's needs beforehand. The DSD stated Resident 1 was agitated in the morning on 12/23/25, so the charge nurse had told her to follow the resident. The DSD stated CNA 3 should have stayed with Resident 1 and not left to pass the lunch trays. The DSD stated Resident 1 could move quickly and the distraction of the lunch trays allowed him to get out of the room undetected.During a telephone interview on 1/13/26 at 4:14 p.m. with CNA 3, CNA 3 stated the altercation between Residents 1 and 2 happened on her third day of orientation on the floor where she was assigned to shadow another CNA on Station 4. CNA 3 stated around 10:00 a.m. the Station 3 charge nurse told her, Hey can you follow him [Resident 1], don't talk to him, he is combative. Just watch him. CNA 3 stated she followed Resident 1 around the facility for a while and he returned to his room. CNA 3 stated the lunch trays came out and she started to help the other CNAs pass the lunch trays. CNA 3 stated she had passed out a few trays and then she saw the ADM walking Resident 1 back to his room. CNA 3 stated LVN 3 then instructed her to stay with Resident 1 until further notice. CNA 3 stated she was not aware she was supposed to provide Resident 1 with 1:1 supervision because it was not clearly communicated to her. CNA 3 stated if she had known she would have stayed with Resident 1. During a review of the facility's policy and procedure (P&P) titled Resident-to-Resident Altercations, dated 9/2022, the P&P indicated, . All altercations, including those that may represent resident-to-resident abuse, are investigated. If two residents are involved in an altercation, staff. separate the residents. identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals. Review the events. evaluate the effectiveness of interventions.During a review of the facility's P&P titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks. are identified on an ongoing basis. interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. (continued on next page)

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