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	04/08/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician (PHY) was notified promptly of a change in condition for one of three sampled residents (Resident 1) when Resident 1 sustained a fall on 3/23/26 at 9:00 p.m. and the resident's mental status declined from alert to unresponsive within one hour of the fall. The resident was sent out to the acute care hospital at 10:45 p.m.This failure resulted in Resident 1's delayed transfer to the acute care hospital (ACH) due to the change in mental status and placed the resident at risk of death from delayed treatment. 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 that included dementia (a progressive state of decline in mental abilities), chronic kidney disease (kidneys are damaged and cannot properly filter waste and extra fluid from the body), hypertensive heart disease (heart damage caused by long-term, unmanaged high blood pressure), and osteoarthritis of the hip (progressive disorder of the joints, caused by gradual loss of cartilage).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 was severely cognitively impaired.During a concurrent interview and record review on 4/7/26 at 11:03 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was at high risk for falls because he would try to self-transfer. Resident 1's Progress Note (PN), dated 3/23/26 at 9:00 p.m. the PN indicated, . at approx [approximately] 2100 [9:00 p.m.] writer was called to room and noted resident on floor in bathroom. Resident was alert and responsive. VS [vital signs] as time of fall was 145/92 @ [at] 2115. [9:15 p.m.] @2130. [9:30 p.m.] 135/92 . @ 2145 [9:45 p.m.] 97/49. @2200 [10:00 p.m.] writer was called back to room to note resident was unresponsive VS [blood pressure] 60/42. [physician's name] gave order to sent to [name of ACH]. EMS [emergency medical service] arrived @2200 and left with resident @2245 [10:45 p.m.]. LVN 1 stated Resident 1 was sent out to the hospital on 3/23/26 because he had a change in mental status and when he returned to the facility he was admitted to hospice (care for individuals with a terminal illness for end of life treatment).During a concurrent interview and record review on 4/8/26 at 2:26 p.m. with LVN 2, Resident 1's SBAR Summary for Providers (SBAR-Situation, Background, Assessment and Recommendation is a tool used to communicate critical information with healthcare providers), dated 3/23/26 at 10:15 p.m., was reviewed. The SBAR indicated, . Mental Status Evaluation: Unresponsiveness. Resident has unwitness fall in the resident bathroom approx. 2100 [9:00 p.m.] assessment done by writer, no visible injury noted.resident was responsive at the time of fall.resident on neuro checks [a neurological exam by healthcare professionals to evaluate a patient's brain and nervous system function].at time of fall. @2200 [10:00 [p.m.] writer was called back to room to note resident was unresponsive VS [blood pressure] 60/42. [name of physician] notified and gave order to send resident to [name of acute care hospital rt [related to] unwitnessed fall. LVN 2 stated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 was a high fall risk and had a history of trying to get up unassisted. LVN 2 stated Resident 1 had an unwitnessed fall on 3/23/26 and was sent to the ACH due to a change in condition. Resident 1's neuro check sheet dated 3/23/26 was reviewed and indicated, . date 3/23 [2026]. 9:00 [p.m.] . BP [blood pressure] . 145/92. Consciousness. Orient [checked] . Response to. Name [checked]. pain [checked]. Environment [checked]. 9:15 [p.m.]. BP 149/102 . Consciousness. Consciousness. Orient [checked] . Response to. Name [checked]. pain [checked]. Environment [checked]. 9:30 [p.m.] BP 135/92 . Consciousness. Orient [marked 0]. Disorient [checked] . Drowsiness [checked]. Response to . Name [marked 0]. Pain [marked 0] Environment [marked 0]. Unresponsive [checked]. 9:45 [p.m.] BP 97/49 . Consciousness. Orient [marked 0]. Disorient [checked] . Drowsiness [checked]. Response to . Name [marked 0]. Pain [marked 0] Environment [marked 0]. Unresponsive [checked]. 10:00 [p.m.] BP 60/42 . Consciousness. Orient [marked 0]. Disorient [checked] . Drowsiness [checked]. Response to . Name [marked 0]. Pain [marked 0] Environment [marked 0]. Unresponsive [checked]. LVN 2 stated Resident 1's blood pressure had dropped between the fall at 9:00 p.m. and 9:30 p.m. and his level of consciousness changed at 9:30 p.m. LVN 2 stated the physician should have been contacted immediately when the resident's mental status changed from alert to drowsy and unresponsive at 9:30 p.m. LVN 2 stated Resident 1 had an unwitnessed fall and the change in mental status could indicate a potential head injury and he would need a medical evaluation. LVN 2 stated there was a half hour lapse in the change of consciousness and the physician notification which was not caught timely.During an interview on 4/8/26 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the LVN notified the Physician, the Nurse Practitioner and herself after the resident fell. The DON stated LVN 3 had started neuro checks. Resident 1's neuro check sheet was reviewed, the resident's blood pressure started to decline started to decline at 9:30 p.m. and level of consciousness decreased. The DON stated the LVN had notified the providers but did not document it. The DON stated the providers recommended monitoring the resident, but if the notification and order were not documented they were considered not done. The DON stated Resident 1's fall happened during the LVN's medication pass and she had checked the resident then continued to pass medications. The DON stated the physician was documented as notified at 10:00 p.m. and the LVN received an order to send the resident to the hospital.During a telephone interview on 4/8/26 at 3:47 p.m. with the Nurse Practitioner (NP), the NP stated he was not aware Resident 1 had a fall on 3/23/26. The NP stated he does not remember speaking to the LVN on 3/23/26 regarding Resident 1's fall or change in condition and the physician was normally on call after 8:00 p.m. The NP stated any resident who had a fall and had a change in the level of consciousness would need to be sent to Emergency Department (ED) as soon as possible because it was a red flag that something was wrong. The NP stated any time a resident falls and there was new disorientation (state of confusion), drowsiness or a significant drop in blood pressure, he would send the resident to the ED because that was a significant change in condition after a fall.During an interview on 4/8/26 at 3:57 p.m. with the Administrator (ADM), the ADM stated the IDT (Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident) IDT-team from different healthcare disciplines who work together to provide comprehensive patient care) had met and discussed Resident 1's fall. The ADM stated if a resident had a fall and the level of consciousness changed the physician would need to be notified promptly and their orders would need to be followed.During a review of Resident 1's History & Physical (H&P) from the ACH dated 3/23/26, the H&P indicated, . found on floor next to toilet at skilled nursing facility at 2100. EMS found the patient hypotensive and patient was transported to [name of ACH] for further care . patient found to be hypotensive. acute kidney injury. left sided pneumonia and patient admitted to the ICU due to upgoing pressor requirement. history of dementia and chronic kidney disease brought in for AMS [altered mental status] s/p [status post] unwitnessed fall at skilled nursing facility. Admit to ICU [intensive care unit-specialized hospital department providing life support for patients with severe or (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	life threatening illnesses].During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated, . Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician on call when there has been. accident or incident involving the resident. significant change in the resident's physical/emotional/mental condition. need to transfer the resident to a hospital. A significant change of condition is a major decline or improvement in the residents status that. will not normally resolve itself without intervention. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) were free from physical restraints when Resident 3 had a position change alarm (bed/chair alarm-alerting device intended to monitor a resident's movement that emits an audible loud sound when the resident moves) put in place for staff convenience, without the resident or responsible party's (RP) consent, medical justification or assessment to evaluate the affect the alarm had on the resident. This failure resulted in Resident 3's movement being restricted because the alarm would sound with small movements which made the resident to feel embarrassed and her privacy was violated causing her to lie in the same position for extended periods of time to prevent the alarm from sounding.During a concurrent observation and interview on 4/7/26 at 10:16 a.m. with Resident 3, in Resident 3's room, Resident 3 was lying in bed flat on her back with discoloration under her right eye. Resident 3 stated she had fallen in the bathroom recently causing her to have a black eye. Resident 3 stated, after the last fall they put this stupid pad under me and an alarm goes off if I move too much. Resident 3 was alert and oriented. Resident 3 stated, I did not want this alarm on my bed. It is loud and I am scared to move.During a review of Resident 3's admission Record, undated, the admission record indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses that included fibromyalgia (chronic disorder involving widespread body pain), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, abnormalities of gait (a person's manner of walking) and mobility (ability to move) and repeated falls.During a review of Residents 3's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 3's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 13 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 3's cognition was not impaired.During a concurrent interview and record review on 4/7/26 at 11:03 a.m. with LVN 1, Resident 3's Order Summary Repot, dated 4/7/26 was reviewed and indicated, .Monitor bed alarm for placement and functionality every shift when in bed or up in wheelchair . LVN 1 stated the bed alarm was ordered on 2/27/26 after her last fall. Resident 3's progress notes were reviewed, LVN 3 stated she was unable to find documentation Resident 3's RP was notified the bed alarm intervention was put into place or that consent was received to use the alarm. LVN 1 stated Resident 3 was alert and oriented, was able to make her needs known, but could be forgetful. LVN 1 stated the bed alarm worked by the resident's weight staying on the pad, and the alarm would sound loudly if the body weight was shifted. LVN 1 stated when the resident moved it could easily set the alarm off. LVN 1 stated she did not know a position alarm could be considered a restraint and did not believe it restricted the resident's movement even if the resident was scared to move because she did not want to set the alarm off. During a concurrent observation and interview on 4/8/26 at 1:02 p.m. with Resident 3, in Resident 3's room, Resident 3 was lying flat on her back in bed. Resident 3 stated the pad alarm sounds if she moved was still under her. Resident 3 stated she stayed in the same position on her back because she did not want to set off the alarm because it embarrassed her. Resident 3 stated, this thing [the alarm] invades my privacy, I cannot move or get up on my own, it bothers everyone because it is really loud.During an interview on 4/8/26 at 1:45 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 3 had a position alarm on her bed, and the alarm would sound loud if the resident moved or lifted her body weight. CNA 4 the alarm was really loud so everyone could hear it. CNA 4 stated Resident 3 had the alarm to prevent her from getting out of bed without supervision and to prevent falls. CNA 4 stated Resident 3 would go to the restroom by herself and was not supposed to, so the alarm was placed to notify staff if the resident tried to get up.During (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a concurrent interview and record review on 4/8/26 at 2:26 p.m. with LVN 2, LVN 2 stated Resident 3 was very impulsive and would get up without assistance. Resident 3's IDT-Accident/Fall (IDT-team from different healthcare disciplines who work together to provide comprehensive patient care), dated 2/25/26 was reviewed and indicated, . Root Cause Analysis: Resident experienced an unwitnessed fall in her room restroom. Resident reported she attempted to get off the toilet without waiting for assistance. Resident remains at very high fall risk due to multiple intrinsic factors. Resident remains at extremely high risk for serious injury with future falls. IDT reinforces that high-risk residents are not to be left unattended during toileting. Due to h/o [history of] multiple falls at home and co-morbidities IDT determined to implement Bed Alarm/Chair Alarm. Purpose: Alert staff of unassisted transfer attempts, Alarm use is strictly for fall prevention and early staff response. Resident retains full freedom of movement. LVN 2 stated the IDT met to review resident falls and determine new interventions to put into place. LVN 2 stated the bed alarm was initiated because other interventions had failed. Resident 3's fall risk care plan, dated 2/18/26, was reviewed, the care plan indicated, . Is At Risk For Falls Related to: Generalized weakness. Unwitnessed [fall] 2/27/26. unwitnessed 3/3/26. Unwitnessed 3/27/26. Witnessed fall 4/2/26. Bed alarm, placement. Purpose: Alert staff of unassisted transfer attempts, Alarm use is strictly for fall prevention and early staff response. Resident retains full freedom of movement. 2/27/26. LVN 2 stated she did not consider the bed alarm a restraint because the resident was able to move, even though the alarm would go off. LVN 2 stated if there was a potential for the alarm to be considered a restraint the facility would need to get informed consent (a process where a medical provider educates a patient about the risks, benefits and alternatives to treatment) from the resident or RP. LVN 2 stated the facility had not gotten informed consent for Resident 3's position change alarm.During an observation on 4/8/26 at 3:15 p.m. with Resident 3, in Resident 3's room, Resident 3 continued to lie flat on her back in bed. Resident 3 stated she did not like the bed alarm.During a concurrent interview and record review on 4/8/26 at 3:30 p.m. with the Director of Nursing (DON), the DON stated when other fall prevention interventions were failing the IDT would determine if a bed alarm was an appropriate intervention. The DON stated the bed alarms were to prevent injury from repeated falls by notifying the staff when the resident got up without assistance. The DON stated Resident 3 had multiple fall interventions in place and continued to fall, but the facility had not attempted one on one supervision for her. The DON stated the facility had not considered the bed alarm a restraint and they had not gotten informed consent from Resident 3 or her RP. The DON stated the nurse would call to notify the RP when a position change alarm was put into place. The DON stated the resident could still get up but it was possible to restrict movement if the resident had a fear of setting the alarm off. The DON stated she was unaware Resident 3 was not moving in bed for fear of setting off the alarm or that the resident did not want the alarm. The DON stated Resident 3's bed alarm was not used to restrain her. The DON stated Resident 3 was alert and oriented with periods of forgetfulness. The DON stated the nurse had spoken to Resident 3's RP and not Resident 3 even though her BIMS showed no cognitive impairment, because she had intermittent confusion.During an interview on 4/8/26 at 3:57 p.m. with the Administrator (ADM), the ADM stated the facility did not have a process in place for bed alarm consents. The ADM stated it was important to get consent for the bed alarms to make sure the RP, and residents understood the risks and benefits of the alarm. The ADM stated if a resident could not make their own decision regarding the bed alarm due to cognition they would defer to the RP for consent. The ADM stated Resident 3 had fall interventions in place which included moving her closer to the nurse's station but he did not recall if one on one supervision had been attempted.During a review of the facility's policy and procedure (P&P) titled Use of Restraints, dated 4/2017, the P&P indicated, . Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amount of time. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement. If the resident cannot remove a device in the same manner in which the staff applied it. and this restricts his/her typical ability to change position. that device is considered a restraint. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.During a review of the facility's P&P titled Resident Alarms, dated 9/2/2022, the P&P indicated, . It is the policy of this facility to utilize residents alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences. an alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected. The use of alarms does not eliminate the need for adequate supervision . Types of alarms include. Bed alarms-including devices such as a sensor pad on the bed. When alarms are used, the interdisciplinary team shall determine whether the alarm meets the definition of a restraint . The resident's assessment to determine whether the alarm meets the definition of a restraint shall be documented.