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	02/06/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 35314 Based on interview, record review, and facility policy review, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was completed and transmitted for 1 (Resident #30) of 2 residents reviewed for discharges. Findings included: A facility policy titled, MDS [Minimum Data Set] Completion and Submission Timeframes, revised 07/2017, indicated, Policy Interpretation and Implementation 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' [Centers for Medicare and Medicaid Services] QIES [Quality Improvement and Evaluation System] Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. The Centers for Medicare and Medicaid Services - Long term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024, revealed, Discharge Assessment-Return Not Anticipated - Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. - Must be completed (item Z0500B [MDS Assessment Completion Date]) within 14 days after the discharge date (A2000 [discharge date] + 14 calendar days). - Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). An Admission Record revealed the facility admitted Resident #30 on 03/17/2024. According to the Admission Record, the resident had a medical history included a diagnosis of type 2 diabetes. According to the Admission Record, Resident #30 discharged from the facility to an acute hospital on 12/07/2024. The MDS data records for Resident #30 revealed the last completed MDS was a quarterly assessment on 09/24/2024, and there was no discharge assessment. During an interview on 02/06/2025 at 8:07 AM, the MDS Coordinator stated Resident #30 did not have a discharge assessment completed. The MDS Coordinator stated a discharge assessment should have been completed, but she had overlooked it. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 8:42 AM, the Director of Nursing (DON) revealed the discharge assessments were completed by the MDS Coordinator. The DON stated she expected the discharge assessments to be completed once the facility was aware of the discharge. During an interview on 02/06/2025 at 9:04 AM the Administrator stated discharge assessments should be completed by the MDS Coordinator.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46194 Based on interview, record review, and facility policy review, the facility failed to ensure resident Minimum Data Set (MDS) assessments were accurate for 4 (Residents #19, #64, #68, and #217) of 28 residents reviewed for MDS accuracy. Findings included: A facility policy titled, MDS Error Correction, revised 09/2010, indicated, The assessment coordinator and/or the interdisciplinary assessment team will follow the established procedures for making corrections to the MDS. The policy revealed, 6. If an error is discovered in a record that has already been accepted by the QIES [Quality Improvement and Evaluation System] ASAP [Assessment Submission and Processing] system, implement procedures for either modification or inactivation of the information in the system within 14 days of the discovery of the error. 1. An Admission Record indicated the facility admitted Resident #217 on 01/21/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of bacteremia. An admission MDS, with an Assessment Reference Date (ARD) of 01/27/2025, revealed Resident #217 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS revealed the resident was receiving intravenous (IV) medications on admission and while a resident within the last 14 days prior to the assessment. The MDS revealed the resident received IV antibiotics on admission. The MDS did not indicate the type of IV access site. Resident #217's Order Summary Report with active orders as of 02/05/2025, revealed an order dated 01/22/2025, for a central veinous catheter (CVC), with instructions to flush with 10 milliliters (ml) of normal saline, infuse medication, then flush with 10 ml of normal saline five times a day. On 02/05/2025 at 11:06 AM, the MDS Coordinator stated that when a resident was admitted to the facility, the staff completed an admission assessment. She stated an IV line and medication would be documented in the MDS assessment. She reviewed the admission MDS completed for Resident #217 and stated there was a section which should have indicated the type of IV line, and it was not coded. On 02/06/2025 at 8:43 AM, the Director of Nursing (DON) stated Resident #217 had a central line (central veinous catheter) on admission. She reviewed Resident #217's admission MDS and stated that the central line section on the MDS should have been coded. She stated the MDS was coded incorrectly. On 02/06/2025 at 9:07 AM, the Administrator stated the MDS coordinator's job was to ensure the MDS assessments were accurate. He stated he expected MDS assessments to be accurate, and communication needed to improve to ensure the accuracy of the MDS assessments. 45555 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An Admission Record indicated the facility admitted Resident #19 on 05/18/2018. According to the Admission Record, the resident had a medical history that included a diagnosis of obstructive sleep apnea. A quarterly MDS, with an Assessment Reference Date (ARD) of 12/20/2024, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS did not indicate that the resident used a non-invasive mechanical ventilator. Resident #19's care plan included a focus area revised 05/06/2024 that indicated the resident was at risk for an alteration in respiratory status related to obstructive sleep apnea. Interventions directed staff to use a BiPAP (bilevel positive airway pressure) machine (a non-invasive mechanical ventilator). Resident #19's Order Summary Report with active orders as of 02/05/2025, revealed an order dated 07/20/2024 for a BIPAP with an inhalation positive airway pressure of 24 centimeter of water (cmH20), exhalation positive airway pressure of 8 cmH20, with 24% fraction of inspired oxygen (FI02) with a goal of 88% blood oxygen saturation (Sp02) level. An observation on 02/03/2025 at 9:41 AM, revealed Resident #19 was in bed. A BiPAP machine was on the resident's nightstand with tubing in a black bag. During an interview on 02/06/2025 at 8:06 AM, the MDS Coordinator stated that information for the MDS came from interviews with the resident and family, observation, her own assessment to gather information, and she looked at other assessments and progress notes from all departments. She stated it was important for the MDS to be accurate for an appropriate care plan to be developed so that they could provide the proper care for the resident. The MDS Coordinator stated the BiPAP should have been coded on Resident #19's MDS. During an interview on 02/06/2025 at 8:29 AM, the Director of Nursing (DON) stated it was important for the MDS to be accurate because it was the communication to the Centers for Medicare and Medicaid (CMS), and it determined the proper care for the resident. She stated it also determined their numbers on the quality measures report. She stated the information for the MDS should come from the resident's record. The DON stated Resident #19's BiPAP should have been coded on the MDS. During an interview on 02/06/2025 at 9:03 AM, the Administrator stated it was important for the MDS to be accurate because it affected the care provided and accurately reflected the resident's needs. He stated the information for the MDS came from the assessments from all departments, and it was the MDS Coordinator's responsibility to ensure the accuracy of the assessments. He stated it was his expectation that the MDS was accurate. He stated Resident #19's BiPAP should have been coded. 3. An Admission Record revealed the facility readmitted Resident #64 on 01/10/2025. According to the Admission Record, the resident had a medical history that included type 2 diabetes mellitus with a foot ulcer, and an acquired absence of the right toe(s). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5-day scheduled assessment MDS, with an Assessment Reference Date (ARD) of 01/14/2025, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident received injections three days during the assessment look-back period. The MDS did not indicate that the resident received insulin injections and antibiotics during the assessment look-back period. Resident #64's care plan included a focus area revised 08/30/2024, that indicated the resident was at risk for hypo/hyperglycemia (low/high blood sugar) related to type 2 diabetes mellitus. Interventions directed staff to administer diabetes medication as ordered by the doctor and monitor and document for side effects and effectiveness (initiated 08/21/2024). The care plan included a focus area revised 01/12/2025, that indicated the resident had an infection and was at risk for adverse reaction to antibiotic therapy. Interventions directed staff to administer antibiotics per the medical doctor's orders (initiated 01/10/2025). Resident #64's Order Summary Report with active orders as of 02/05/2025, revealed an order dated 01/10/2025 for Augmentin (an antibiotic) 500 - 125 milligrams (mg) with instructions to give one tablet by mouth every eight hours for prophylactic foot surgery for 28 days. The Order Summary Report revealed an order dated 01/10/2025 for Humalog (insulin lispro) 100 units per milliliter (ml) with instructions to inject per sliding scale subcutaneously before meals. Resident #64's January 2025 Medication Administration Record [MAR], revealed staff documented that they administered Augmentin 500 - 125 mg once on 01/10/2025, three times a day on 01/11/2025, 01/12/2025, and 01/14/2025, and twice on 01/13/2025, during the MDS look-back period. The MAR revealed staff documented that they administered Humalog insulin during the MDS look-back period on 01/11/2025 at 4:30 PM, 01/13/2025 at 12:00 PM, and 01/14/2025 at 12:00 PM. During an interview on 02/06/2025 at 8:06 AM, the MDS Coordinator stated that information for the MDS came from interviews with the resident and family, observation, her own assessment to gather information, and she looked at other assessments and progress notes from all departments. She stated it was important for the MDS to be accurate for an appropriate care plan to be developed so that they could provide the proper care for the resident. The MDS Coordinator stated Resident #64 received insulin and after reviewing Resident #64's MDS she confirmed that it was not coded on the MDS but should have been. She stated she documented three injections but did not code the actual insulin. She also confirmed that the MDS should have been coded for the resident taking an antibiotic. During an interview on 02/06/2025 at 8:29 AM, the Director of Nursing (DON) stated it was important for the MDS to be accurate because it was the communication to the Centers for Medicare and Medicaid (CMS), and it determined the proper care for the resident. She stated it also determined their numbers on the quality measures report. She stated the information for the MDS should come from the resident's record. She stated they should look under the active orders to determine what medications the resident was taking. She stated Resident #64 was receiving an antibiotic and insulin, and the medications should have been properly coded on the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/06/2025 at 9:03 AM, the Administrator stated it was important for the MDS to be accurate because it affected the care provided and accurately reflected the resident's needs. He stated the information for the MDS came from the assessments from all departments, and it was the MDS Coordinator's responsibility to ensure the accuracy of the assessments. He stated it was his expectation that the MDS was accurate. He stated Resident #64's medications should have been coded on the MDS. 4. An Admission Record indicated the facility admitted Resident #68 on 12/14/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar disorder. An admission MDS, with an Assessment Reference Date (ARD) of 12/20/2024, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was taking an antipsychotic medication with the indication noted. However, the section titled N0450. Antipsychotic Medication Review revealed it was incorrectly coded to indicate that antipsychotics were not received, and this caused the assessment to skip information related to gradual dose reduction (GDR). Resident #68's care plan included a focus area revised 12/17/2024, that indicated the resident received an antipsychotic medication for bipolar disorder. Interventions directed staff to administer medication as ordered and consult with the physician to consider dose reduction at least every three months. Resident #68's Order Summary Report with active orders as of 02/05/2025, revealed an order dated 12/14/2024, for quetiapine fumarate 50 milligrams (mg) with instructions to give one tablet by mouth two times a day for bipolar disorder. Resident #68's December 2025 Medication Administration Record [MAR], revealed staff documented that the resident received quetiapine fumarate 50 mg twice a day during the MDS look-back period from 12/15/2024 through 12/20/2024. During an interview on 02/06/2025 at 8:06 AM, the MDS Coordinator stated that information for the MDS came from interviews with the resident and family, observation, her own assessment to gather information, and she looked at other assessments and progress notes from all departments. She stated it was important for the MDS to be accurate for an appropriate care plan to be developed so that they could provide the proper care for the resident. The MDS Coordinator stated Resident #68 was taking an antipsychotic medication and after reviewing the MDS she confirmed that section N0450 was coded incorrectly. She stated it should have indicated that the resident was taking an antipsychotic. She stated it was overlooked. During an interview on 02/06/2025 at 8:29 AM, the Director of Nursing (DON) stated it was important for the MDS to be accurate because it was the communication to the Centers for Medicare and Medicaid (CMS), and it determined the proper care for the resident. She stated it also determined their numbers on the quality measures report. She stated the information for the MDS should come from the resident's record. She stated they should look under the active orders to determine what medications the resident was taking. The DON stated Resident #68's MDS should have been coded to reflect the use of the antipsychotic on all parts of the MDS to ensure the accuracy of the assessment. She confirmed that section N0450 of the MDS was coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/06/2025 at 9:03 AM, the Administrator stated it was important for the MDS to be accurate because it affected the care provided and accurately reflected the resident's needs. He stated the information for the MDS came from the assessments from all departments, and it was the MDS Coordinator's responsibility to ensure the accuracy of the assessments. He stated it was his expectation that the MDS was accurate. He stated Resident #68's medication should have been coded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure reusable resident care equipment was cleaned and disinfected after use and failed to ensure enhanced barrier precautions (EBP) were used for 1 (Resident #64) of 1 resident observed during wound care. Findings included: A facility policy titled, Enhanced Barrier Precautions, revised 09/27/2024, specified, Definitions: 'Enhanced barrier precautions' refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g. [exempli gratia, for example], residents with wounds or indwelling medical devices). The policy revealed the section titled, Policy Explanation and Compliance Guidelines, included, c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. 2. Initiation of Enhanced Barrier Precautions - a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers). The policy also indicated, 3. Implementation of Enhanced Barrier Precautions - a. Make gowns and gloves available PRIOR TO PERFORMING TASKS. A facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, specified, d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). An Admission Record indicated the facility readmitted Resident #64 on 01/10/2025. According to the Admission Record, the resident had a medical history that included diagnoses of acquired absence of other right toe(s) and an encounter for orthopedic aftercare following surgical amputation. A 5-day scheduled assessment Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2025, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #64 had a surgical wound. Resident #64's care plan included a focus area initiated 01/12/2025, that indicated the resident had altered non-pressure skin integrity related to a surgical wound to the right foot. Interventions directed staff to provide treatments as ordered (initiated 01/12/2025). Resident #64's Order Summary Report, with active orders as of 02/05/2025, revealed an order dated 01/30/2025, to cleanse the resident's right foot transmetatarsal amputation (TMA) with normal saline, pat dry, and apply Medihoney when wrap with a gauze bandage every other day for surgical wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/03/2025 at 9:10 AM, revealed Resident #64 had a dried bloody dressing to the right foot. The observation revealed no EBP signage inside the room or outside the room in the hallway, and there was no PPE, including gowns, available in the room or in the hallway outside the room. An observation on 02/05/2025 at 1:16 PM, revealed Licensed Vocational Nurse (LVN) #2, who was also the treatment nurse, and LVN #3 entered Resident #64's room to provide wound care. LVN #2 and LVN #3 entered the resident's room after performing hand hygiene and donned gloves. LVN #2 and LVN #3 did not don a gown. LVN #2 was observed cutting off the resident's old dressing on their right foot with scissors. After providing wound care, LVN #2 was observed taking the scissors to the treatment cart and putting them in the drawer without cleaning or sanitizing them. During an interview conducted immediately after the provision of wound care, LVN #2 stated there was no signage up on the doorway and there were no PPE supplies available, so she did not think about EBP. LVN #2 stated that since the resident did have a wound that required a dressing, they should have put on gowns while providing the wound care. LVN #2 stated Resident #64 should have been put on EBP by the Infection Preventionist (IP) when the wound opened up and started requiring a dressing change. LVN #2 stated the scissors should have been cleaned and disinfected after using them. LVN #2 stated she should have placed them on a paper towel on the cart to prevent contamination and then cleaned them before they were put back in the drawer, but she was nervous and forgot. During an interview on 02/05/2025 at 2:29 PM, LVN #3 stated EBP should be used when a resident had an open wound that required a dressing to help prevent the spread of infection. LVN #3 stated she went into the room with LVN #2 as the interpreter and did not think about needing to put on a gown for EBP. During an interview on 02/05/2025 at 2:46 PM, the IP stated they started doing EBP in November (2024) for residents with chronic wounds, MDROs, dialysis access, gastrostomy tubes, catheters, colostomies, and intravenous (IV) access. The IP stated if the resident had an ulcer or open wound then they would need the EBP to prevent them from getting an infection. The IP stated she was the person responsible to put the precautions in place. The IP stated Resident #64 had a surgical incision that was an open wound that needed a dressing, and they should have been on EBP. The IP stated the nurses should have notified her, and they should have caught that EBP was needed. The IP stated training had been done on EBP at least every two weeks, and it was ongoing. The IP stated any reusable equipment used during wound care needed to be cleaned and disinfected after use, and the scissors should not have been put back into the cart without being cleaned first. During an interview on 02/06/2025 at 8:29 AM, the Director of Nursing (DON) stated reusable equipment should be disinfected immediately after the wound care was provided. The DON stated EBPs should be used on all residents with wounds, chronic pressure wounds, and when the staff had any contact with bodily fluids. The DON stated the IP was responsible to ensure that the EBPs were in place. The DON stated the staff had been educated, and the treatment nurse and the nurse assisting should have been using the gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 9:03 AM, the Administrator stated staff should clean and disinfect reusable equipment after use for infection control reasons. The Administrator stated EBPs should be used with residents that had open wounds, dialysis access, and IV access sites. The Administrator stated staff should be aware of who was on the precautions, the proper signage should be up, and the cart with the PPE should be available. The Administrator stated Resident #64 had a change in condition with the wound, and the treatment nurse did not communicate it with the IP to update the information. During an interview on 02/06/2025 at 9:39 AM, the IP stated she was not aware that Resident #64's wound opened up and EBP was required. The IP stated it was a lack of communication between her and the treatment nurse.