STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105604	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village Care Center	9211 W Broward Blvd Plantation, FL 33324

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to initiate a care plan for monitoring behaviors and side effects for 2 of 5 sampled residents on psychotropic medications (Resident #268 and Resident #33). Facility also failed to initiate a care plan for monitoring pain for 1 of 5 sampled residents on narcotic medications (Resident #268). The findings included: 1. A record review showed that Resident #268 was admitted on [DATE] with diagnosis of Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side and Epilepsy, not intractable, without status epilepticus. The Minimum Data Set (MDS) comprehensive dated 05/04/2025 revealed that the Brief Interview of Mental Status (BIMS) score is 14, which indicated intact cognition. A review of the orders revealed the following: 04/30/25: Divalproex 125 mg tablet, delayed release Every 12 Hours. 04/30/25: Tramadol 50 mg tablet as needed Every 4 Hours. 05/01/25: Enoxaparin 40 mg/0.4 mL subcutaneous syringe 1 Time Daily for 30 Days. 05/01/25: Pain Assessment 05/01/25: Behavior Monitoring 05/01/25: Side Effect Monitoring A review of Resident #268 medication administration record (MAR) indicated that the behaviors and side effects were being monitored. The pain assessment was also completed. A review of the comprehensive care plan dated 05/13/25 stated that Resident #268 is at risk for potential bleeding related to Anticoagulant Therapy. And monitoring of bruising and bleeding to put in place. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the comprehensive care plan dated 05/13/25 indicated that no care plan was put in place for monitoring behaviors or side effects related to the use of psychotropic medications or pain assessment related to the use of narcotics. 2. A record review showed that Resident #33 was admitted on [DATE] with diagnosis of Urinary tract infection and Parkinsonism. The Minimum Data Set (MDS) 5 days dated 04/28/2025 revealed that the Brief Interview of Mental Status (BIMS) score is 10, which indicated moderate cognitive impairment. A review of the orders revealed the following: 04/23/25: Eliquis 5 mg tablet Every 12 Hours for 30 Days. 04/23/25: Gabapentin 100 mg capsule Every 12 Hours. 04/28/25: Escitalopram 10 mg tablet Hour of Sleep. 04/23/25: Side Effect Monitoring every Shift . 04/23/25: Behavior Monitoring every Shift. 04/23/25: Pain Assessment every Shift. A review of Resident #33 medication administration record (MAR) indicated that the behaviors and side effects were being monitored. The pain assessment was also completed. A review of the comprehensive care plan dated 05/06/25 stated that Resident #33 is at risk for potential bleeding related to Anticoagulant Therapy. And monitoring of bruising and bleeding to put in place. A review of the comprehensive care plan dated 05/06/25 stated that Resident #33 is receiving antidepressant drugs on a regular basis. And monitoring for side effects and mood and behaviors to put in place. A review of the comprehensive care plan dated 05/13/25 indicated that no care plan was put in place for monitoring behaviors or side effects related to the use of psychotropic medications. In an interview conducted on 05/14/25 at 10:55 AM, the minimum data set (MDS) coordinator stated that Resident #268 is on psychotropic medications for seizures not for psychiatric problems and on narcotics for pain. She further explained that when psychotropics are not given for psychiatric disorders it's not necessary to monitor the resident for side effects nor for behaviors and mood. The MDS coordinator acknowledges the missing care plan for narcotics use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39026 Based on observation, interviews, record review and policy review, the facility failed to remove narcotics from 2 of 3 medication carts for residents who have no current orders for the narcotics. The findings included: The facility's policy titled Discarding and Destroying Medications revised 10/2014 revealed Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. On 05/15/25 at 12:05 PM, medication cart east was reviewed with Staff C, Registered Nurse (RN). Upon review of the as needed (prn) narcotics, Resident #4's medication card for Alprazolam 0.25 milligrams (mg) was in the narcotic locked box with no current order and last given on 03/11/25. The order was discontinued on 11/26/24. On 05/15/25 at 12:15 PM, medication cart middle was reviewed with Staff A, RN. Resident #17's medication card for Hydrocodone 5 mg-acetaminophen 325 mg was in the narcotic locked box with no current order and last given on 04/21/25. The order was discontinued on 02/21/25. This was discussed with the Administrator on 05/15/25 at 12:30 PM.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52179 Based on observations, interview, and record review, the facility failed to implement interventions to monitor side effects and behaviors related to antidepressant medication for 1 out of 5 residents reviewed for Unnecessary Medications (Resident # 13). The findings included: Record review for Resident # 13 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Dementia, a condition characterized by a progressive decline in affecting memory, thinking, language, and behavior and Major Depressive Disorder. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident # 13 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated that she was moderately cognitively impaired. Review of Section GG of the MDS dated [DATE] revealed that the resident needed supervision and assistance for activities of daily living. Review of the Physician's Orders showed that Resident # 13 had an order dated 02/25/25 for Fluoxetine 10 mg capsule every morning for depression. Review of the Care Plan dated 03/01/25 documented that Resident #13 had an active order for medication to treat depression. Goals were to observe Resident #13 for changes in mood/behavior (sleep patterns, fatigue, appetite, ability to concentration, participation in activities, crying) and to record behaviors on the Behavior Tracking form. Review of the Treatment Plan for Resident # 13, date 02/25/25, lacked documentation of side effects monitoring or behavior observations. During a side-by-side review of the record and interview on 05/14/25 at 9:28 AM with Staff Nurse C, Registered Nurse (RN), she confirmed the lack of a physician order for behavioral monitoring for the medication Fluoxetine. She stated that the resident refuses her medications on most days. The last recorded administration date and time of Fluoxetine 10 mg was on 05/10/25 at 9:00 AM. The electronic record revealed that there was no behavioral monitoring for Resident #13 and the Staff Nurse agreed that the resident should be monitored.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39026 Based on observation, interview, record and policy review, it was determined that the medication error rate was 7.14 percent, 2 medication errors were identified while observing a total of 28 opportunities, affecting Resident #323. The findings included: The facility's policy titled Medication Administration implemented 01/2001 and revised 04/2019 revealed Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. On 05/15/25 at 10:04 AM, Staff B, Registered Nurse (RN) was observed preparing medication for Resident #323. Resident #323's blood pressure was 105/82, and heart rate was 55. Staff B prepared Amoxicillin 500 milligrams (mg) 1 tablet po (by mouth), Carvedilol 6.25mg 1 tablet po. The parameters for Carvedilol were to hold for SBP<110 DBP <60 HR <60. (Hold for systolic blood pressure under 110 and diastolic blood pressure under 50 and heart rate under 60). She also prepared 6 other medications. The Surveyor intervened after Staff B walked into the resident's room to give the medication and asked her to review the orders for Amoxicillin and Carvedilol. Staff B reviewed the orders and stated she should have prepared 2 pills for Amoxicillin and should not have prepared Carvedilol because the resident's blood pressure was under 110/60 and heart rate was under 60. This was discussed with the Administrator on 05/15/25 at 11:00 AM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview and policy review, the facility staff failed to lock the medication cart during medication administration for 1 of 9 residents observed for medication administration and failed to properly dispose a wasted drug during medication administration. The findings included: The facility's policy titled Medication Labeling and Storage revised 02/2023, revealed Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transfer such items are not left unattended if open or otherwise potentially available to others. On 05/14/25 at 9:20 AM, Staff B, Registered Nurse (RN) was observed leaving her medication cart unlocked while going into the room to give medication to Resident # 219. This cart continued to be unlocked during the time the cart was pushed to room [ROOM NUMBER] to give medications to Resident #121. Staff B took Resident #121's vitals at 9:25 AM. Then washed her hands in the bathroom with the cart parked outside of the door of the room unlocked. At this time a Certified Nursing Assistant (CNA) was walking in and out of the resident's room and other residents were being pushed in their wheelchairs to physical therapy with the physical therapists. At 9:36 AM the resident was given medication with the cart still unlocked in front of the door. Observation continued with Staff B during medication administration. Staff B pushed the medication cart to room [ROOM NUMBER] at 9:47 AM. The cart was now parked in front of room [ROOM NUMBER] unlocked. Resident #24 was given medications then Staff B returned to her medication cart at 9:56 AM and locked it. Staff B then prepared medications for Resident #323 at 10:04 AM in the same room. The cart was unlocked to prepare the medications. Staff B prepared 6 medications and put them in the medication cup then spilled the 7th medication. The medication (Glipizide ER (extended release) 5 milligrams was picked up by Staff B and put into the trash receptacle. The Surveyor asked Staff B if that is where the discarded medication goes and she said it should go into the pill buster and stated she was sorry about that. Staff B prepared 3 more medications then locked the cart and went into the resident's room to administer the medications. This was discussed with the Administrator on 05/14/25 at 11:00 AM.