| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195614 | A. Building<br>B. Wing | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Covenant Home | 5919 Magazine Street<br>New Orleans, LA 70115 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39158<br><br>Based on interviews and record reviews, the facility failed to ensure a resident was free from verbal and mental abuse from S2Certified Nursing Assistant (CNA). This deficient practice was identified for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for abuse.<br><br>Findings:<br><br>Review of the facility's policy titled, Identification of Types of Abuse (Reviewed April 2023) revealed, in part, on page 1:<br><br>1. Verbal abuse is defined as oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, employees or families that are within hearing distance regardless of their age, ability to comprehend or disability.<br><br>4. Mental abuse can be defined as, but is not limited to, humiliation, harassment, threats of punishment or deprivation.<br><br>Review of the Admission MDS (Minimum Data Set) with an ARD (Assessment Resident Date) of 05/14/2024 revealed Resident #1 had a BIMS (Brief Interview for Mental Status) of 13 (cognitively intact), with adequate hearing and vision, and exhibited no physical and verbal behavioral symptoms.<br><br>Review of Resident #1's medical record revealed he was admitted to the facility on [DATE] with diagnoses, in part, Aphasia.<br><br>In an interview on 06/17/2024 at 8:25 a.m., S1Administrator indicated verbal and mental abuse was substantiated for Resident #1 by S2CNA.<br><br>Review of the Statewide Incident Management System (SIMS) #170430 entered on 05/28/2024 at 3:18 p.m. revealed verbal and mental abuse was substantiated by the facility. Further review revealed the victim, Resident #1, was abused by S2CNA on 05/24/2024 who was terminated as a result of the facility investigation. Still further review revealed Resident #2 witnessed this incident.<br><br>In an interview on 06/17/2024 at 1:10 p.m., Resident #2 indicated he heard S2CNA yell what the hell do think you are doing three times at Resident #1.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/18/2024 at 12:35 p.m., Resident #1 indicated S2CNA had yelled at him on 05/24/2024.<br><br>In an interview on 06/18/2024 at 2:30 p.m., S1Administrator indicated the facility substantiated verbal and mental abuse of Resident #1 by S2CNA, and S2CNA was terminated. S1Adminstrator indicated mental abuse was substantiated because other residents also report the verbal abuse from S2CNA. |