STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195614	A. Building B. Wing	05/21/2025

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observations, interviews, and record reviews, the facility failed to ensure a notice of employees' rights against retaliation for reporting crimes against residents was posted in a conspicuous location. Findings: Review of the United States Social Security Act Title XI, Part A, Section 1150B(d)(3) dated 08/14/1935 and amended on 09/26/2024 revealed, in part, each long-term care facility shall post conspicuously in an appropriate location a sign specifying the rights of employees against retaliation for reporting crimes against residents of the facility. Further review revealed, such sign shall include a statement that an employee may file a complaint against a long-term care facility that violates the provisions against retaliation with respect to the manner of filing such a complaint. Observation of the facility's employee common areas on 05/19/2025 at 1:00PM revealed no conspicuous signage related to employees' rights against retaliation for reporting suspected crimes. In an interview on 05/20/2025 at 2:10PM, S10Licensed Practical Nurse indicated there was no signage displayed for staff members indicating employees' rights against retaliation for reporting suspected crimes. In an interview on 05/20/2025 at 3:33PM, S2Director of Nursing (DON) indicated the facility could not provide any evidence a sign was posted in a conspicuous location regarding.employees' rights against retaliation for reporting suspected crimes. S2DON further indicated she had never seen a sign posted with the above mentioned information on it. In an interview on 05/21/2025 at 12:30PM, S3Registered Nurse/Treatment Nurse indicated she had not observed signage related to employees' rights and the prohibition and prevention of retaliation for reporting suspected crimes. In an interview on 05/21/2025 at 1:35PM, S1Administrator indicated the facility could not provide any evidence a sign was posted in a conspicuous location regarding employees' rights against retaliation for reporting suspected crimes as required.

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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(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** Based on interviews and record reviews, the facility failed to ensure a care plan was developed for a resident to decrease the risk of skin tear injuries for 1 (Resident #43) of 2 (Resident #6, Resident #43) sampled residents investigated for accidents. Findings: Review of Resident #43's medical record revealed, in part, Resident #43 was admitted to the facility on [DATE] with diagnoses which included, in part, laceration to the left forearm, muscle weakness, lack of coordination, vision problems, and vascular dementia. Review of Resident #43's May 2025 physician's orders revealed, in part, an order to administer Plavix (a medication used to prevent blood clots and increases the risk of bleeding) 75 milligrams (mg) one tablet by mouth daily. Review of the facility's incident and accident log dated February 2025 through May 2025 revealed, in part, the following incidents involving Resident #43: - 02/20/2025 at 5:00AM: injury incident (skin tear); - 03/08/2025 at 12:00AM: injury incident (skin tear); - 03/19/2025 at 5:30AM: injury incident (skin tear); - 04/04/2025 at 4:45AM: injury incident (skin tear); and, - 04/04/2025 at 12:00AM: injury incident (skin tear). Review of Resident #43's care plan revealed no documented evidence and the facility did not present any documented evidence Resident #43 had a care plan developed to address safety prevention measures to prevent accidents resulting in skin tear injuries. There was no documented evidence and the facility could not provide any documented evidence Resident #43's plan of care included interventions for the prevention of skin tear injuries. In an interview on 05/21/2025 at 12:30PM, S3Registered Nurse/Treatment Nurse (RN/TN) confirmed Resident #43's above mentioned skin tear injuries. S3RN/TN further indicated the facility could not provide any documented evidence a care plan was developed for Resident #43 to address risk factors and interventions to keep Resident #43 safe from injuries and should have been. In an interview on 05/21/2025 at 1:35PM, S1Administrator was presented with the above mentioned findings and could offer no explanation for the reason as to why Resident #43's plan of care did not include prevention interventions for skin tear injuries. th

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews and record reviews, the facility failed to ensure a resident with a urinary tract infection (UTI) received antibiotic medication as ordered for 1 (Resident #50) of 1 (Resident #50) sampled resident investigated for UTIs. Findings: Review of the facility's Administering Medication policy and procedure, dated 08/2020 revealed, in part, medications should be administered as ordered. Review of the facility's Emergency Drug Kit inventory form dated 05/19/2025 revealed, in part, 6 doses of Sulfamethoxazole/Trimethoprim (a medication used to treat bacterial infections) 800/160 milligrams (mg) oral tablets available for resident use. Review of Resident #50's medical record revealed, in part, Resident #50 was diagnosed with a UTI on 05/13/2025. Review of Resident #50's May 2025 physician's orders revealed, in part, an order dated 05/13/2025 to administer Resident #50 one tablet of Sulfamethoxazole/Trimethoprim 800/160 mg by mouth twice daily for 7 days for treatment of a UTI. Further review revealed the medication should have been started on 05/14/2025 at 8:00AM. Review of Resident #50's May 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #50 was not administered one Sulfamethoxazole Trimethoprim 800-160 mg oral tablet on 05/14/2025 at 8:00AM as ordered. In an interview on 05/19/2025 at 2:20PM, S7Licensed Practical Nurse (LPN) indicated the above mentioned medication was available in the facility's Emergency Drug Kit and should have been administered to a resident if the medication was due and not available from the pharmacy. In an interview on 05/20/25 08:31AM, S9LPN indicated if an ordered medication had not been received from pharmacy to administer when the medication was due, the nurse should chart the medication as not available. S9LPN further indicated she did not know what medications were available to administer in the facility's Emergency Drug Kit. In an interview on 05/20/2025 at 3:33PM, S2Director of Nursing (DON) indicated a resident that had a medication due that had not been delivered by pharmacy, but was available in the Emergency Drug Kit, the medication should have been administered from the Emergency Drug Kit. In an interview on 05/21/2025 at 12:30PM, S3Registered Nurse/Treatment Nurse (RN/TN) confirmed Resident #50 should have received his morning dose of Sulfamethoxazole Trimethoprim on 05/14/2025 as ordered. RN/TN further indicated the above mentioned medication was available in the facility's Emergency Drug Kit and should have been administered to Resident #50 on 05/14/2025. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/21/2025 at 1:35PM, S1Administrator was presented with the above mentioned findings and could off no explanation as to why Resident #50 was not administered a medication as ordered if that medication was available in the facility's Emergency Drug Kit for use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to: 1. Ensure medications were available for administration for 1 (Resident #58) of 5 (Resident #31, Resident #42, Resident #43, Resident #51, Resident #58) residents reviewed for medication administration; and, 2. Ensure an accurate and/or complete controlled medication reconciliation for 1 (Medication Cart a) of 2 (Medication Cart a, Medication Cart b) medication carts reviewed. Findings: 1. Review of the facility's Administering Medication policy and procedure, dated 08/2020, revealed, in part, medications should be administered as ordered. Review of Resident #58's medical record revealed, in part, Resident #58 was admitted to the facility on [DATE] with a diagnoses of, in part, dementia, unspecified Psychosis (a disorder characterized by a distorted perception of reality), Parkinson's disease (a progressive brain disorder which affects the body's movements) with anxiety. Review of Resident #58's physician's orders revealed, in part, an order for Klonopin (a medication used to treat anxiety) 0.5 milligrams (mg) administer 1 tablet by mouth two times a day. Review of Resident #58's Nursing Administration Notes dated 05/16/2025, 05/17/2025, 05/18/2025 and 05/19/2025 revealed, in part, Resident #58's Klonopin (medication used for anxiety) 0.5 milligrams (mg) was not available for use from the pharmacy. Review of Resident #58's Nursing Administration Note dated 05/20/2025 revealed, in part, Resident #58 did not receive Klonopin as ordered because the medication was not received from pharmacy. Review of Resident #58's May's 2025's e-Medication Administration Record (e-MAR) revealed, in part, Resident #58's Klonopin 0.5 mg by mouth was not available to be administered on the following dates: 05/16/2025- 6:00 AM and 6:00 PM; 05/17/2025-6:00 AM and 6:00PM; 05/18/2025-6:00 AM and 6:00 PM; and, 05/19/2025-6:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/19/2025 at 2:16PM, S9Licensed Practical Nurse (LPN) indicated that Resident #58's Klonopin was unavailable since 05/16/2025. In an interview on 05/21/2025 at 11:48PM, S3Registered Nurse (RN)/Treatment Nurse indicated Resident #58's Klonopin was not administered as ordered for the above mentioned dates due to the medication not being received from the pharmacy. In an interview on 05/21/2025 at 1:30PM, S1Administrator confirmed that she was aware of Resident #58's Klonopin medication not being available for the above dates, and should have been. 2. Review of the facility's Administering Controlled Substances policy and procedure, dated 07/2020, revealed, in part, staff members receiving controlled substances should verify the amount of medication received, sign their name, date, time, and amount of medication received on the first line of the resident's narcotic record. Further review revealed staff coming on duty counts the number of pills in the container, and if the pill count is the same, both staff complete the narcotic count form. Review of the facility's undated Controlled Drug Inventory form revealed, in part, at each shift change, the oncoming and off going nurses were to count the number of controlled drug packages/cards in the control box and verify that number listed under total number on hand. Further review revealed a nurse should sign and have another nurse witness, verifying the amount received and/or on hand. Review of Resident #36's Controlled Substance Count Sheet revealed, in part, no date and time the controlled substance was received, the amount distributed was inaccurate, amount on hand was not completed, and no nurse's signatures verifying the received controlled substance count was correct for the following medications: - temazepam (a medication used to treat anxiety and insomnia) 15 milligrams (mg); - lorazepam (a medication used to treat anxiety and insomnia) 2mg/milliliter (mL); and, - morphine (a medication used to treat pain) 20 mg/mL. Review of Resident #18's Controlled Substance Count Sheet revealed no date and time the controlled substance was received for the following medications: - lorazepam 2mg/mL; and, - morphine 20 mg/mL. There was no documented evidence and the facility did not present any documented evidence of having a complete and accurate record of receipt and disposition of all the above mentioned controlled medications for Resident #18 and Resident #36. Review of the facility's April/May 2025 Medication Cart a Controlled Drug Inventory revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart b's controlled substances with the oncoming nurse on: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 04/28/2025 for the 11:00PM shift change; and, - 04/30/2025 for the 3:00PM shift change. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart a's controlled substances with the off going nurse on 04/28/2025 for the 11:00PM shift change. Further review revealed inventory was not completed on: - 04/24/2025 for the 11:00PM shift change; - 04/25/2025 for the 7:00AM shift change; - 04/25/2025 for the 11:00PM shift change; - 04/28/2025 for the 11:00PM shift change; - 04/30/2025 for the 3:00PM shift change; and - 05/07/2025 for the 7:00PM shift change. There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart a for the above mentioned dates and/or times. Review of the facility's April/May 2025 Medication Cart b Controlled Drug Inventory revealed, in part, no entry was completed for a controlled drug inventory reconciled by 2 nurses on: - 05/14/2025 for the 7:00AM-3:00PM shift; - 05/16/2025 for the 7:00AM-3:00PM shift; and, - 05/16/2025 for the 3:00PM-11:00PM shift; There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart b for the above mentioned dates and/or times. In an interview on 05/20/2025 at 9:05AM, S10LPN indicated she completed the Controlled Drug Inventory form and signed for the end of her shift at the beginning of her shift and should not have. In an interview on 05/21/2025 at 12:30PM, S3Registered Nurse/Treatment Nurse (RN/TN) indicated the above mentioned controlled substance reconciliations were incomplete and/or inaccurate and should not have been. S3RN/TN further indicated controlled substance forms should have been complete and accurate with the correct dates, shifts, inventory amounts, and verified by 2 nurses' signatures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/21/2025 at 1:35PM, S1Administrator was presented with the above mentioned findings and could offer no explanation as to why the controlled substance reconciliations were inaccurate and or incomplete.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interviews, and record reviews, the facility failed to ensure an expired medication was not available for resident use in 1 (Medication Cart b) of 2 (Medication Cart a, Medication Cart b) medication carts reviewed for expired medications. Findings: Review of the facility's Storage of Medications policy and procedure, dated 08/2020, revealed, in part, no discontinued, outdated, or deteriorated medications were to be used in this facility. Further review revealed all such medications were recycled or destroyed per facility policy. Review of Resident #52's May 2025 physician's orders revealed, in part, an order to administer Resident #52 one tablet of atorvastatin (a medication used to lower cholesterol) 20 milligrams (mg) by mouth daily. Observation on 05/20/2025 at 9:10AM of Medication Cart b revealed a bottle of Resident #52's atorvastatin 20 mg with a discard by date of 04/30/2025 and was available for Resident #52's use. In an interview on 05/20/2025 at 9:15AM, S10Licensed Practical Nurse indicated the above mentioned medication was expired and available for Resident #52's use and should not have been. In an interview on 05/20/2025 at 9:25AM, S2Director of Nursing confirmed the above mentioned medication was expired and available for Resident #52's use and should not have been.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure: 1. Food was stored in a sanitary manner; and, 2. Food was thawed in an appropriate manner. Findings: 1. Observation of the facility's kitchen refrigerator on 05/18/2025 at 9:13AM revealed an opened half full box of uncooked bacon was stored on the shelf above seven and a half quarts of orange juice. Further observation of the facility's refrigerator revealed an opened and undated package of shredded cheddar cheese, an opened and undated package of multiple slices of American cheese, an opened and undated container of liquid eggs, an opened and undated container of sour cream, and an opened and undated gallon container of Italian dressing which was approximately one-eighth full. Further observation revealed an unlabeled, undated package (which was identified by S5Cook as crab cakes), an unlabeled, undated container (which was identified by S5Cook as peas), and an unlabeled, undated bag of cooked meat. In an interview on 05/18/2025 at 9:25AM, S5Cook indicated all food items in the facility's refrigerator should be labeled with an opened/prepared date and/or the contents of the bag/package/container. S5Cook further indicated meat items should not be stored above other food items. Observation on 05/18/2025 at 9:34AM revealed 14 undated individually wrapped sandwiches (turkey/mayonnaise, ham/mayonnaise, and peanut butter/jelly) present on a tray which did not allow temperature regulation. In an interview on 05/18/2025 at 9:36AM, S5Cook indicated the above mentioned sandwiches were prepared on the evening shift of 05/17/2025 for residents for lunch and dinner on 5/18/2025. S5Cook further indicated the above mentioned sandwiches were removed from the refrigerator around 5:00AM on 5/18/2025 for use on 5/18/2025. Observation on 05/18/2025 at 9:36AM revealed the temperature of a random turkey/mayonnaise sandwich from the above mentioned tray was 74 degrees Fahrenheit. Further observation revealed the temperature of a random ham/mayonnaise sandwich from the above mentioned tray was 71.5 degrees Fahrenheit. In an interview on 05/21/2025 at 12:37PM, S4Dietary Manager (DM) indicated the food in the facility's refrigerator should be labeled with an opened/prepared date and/or a description of the contents of the container. S4DM further indicated the above mentioned sandwiches should have been stored in the facility's refrigerator to keep them at an appropriate temperature.S4DM further indicated the bacon should not have been stored over other food items and should have stored on the bottom shelf. 2. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/21/2025 at 12:40PM revealed 5 bags of raw chicken with holes in the bags, to allow the liquid in the sink to enter the bags, were submerged in standing water in the facility's sanitization sink. Further observation revealed the water was not running over the chicken. In an interview on 05/21/2025 at 12:42PM, S4DM confirmed S6Cook was defrosting the raw chicken in the facility's sanitization sink and should not have been. S4DM further indicated raw chicken should have been defrosted in the kitchen's refrigerator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's electronic Medication Administration Record (eMAR) was accurately documented for 1 (Resident #58) of 5 (Resident #31, Resident #42, Resident #43, Resident #51, Resident #58) sampled residents reviewed for accurate medical record documentation for medication administration. Findings: Review of the facility's Administering Medication policy and procedure, dated 08/2020, revealed, in part, medications should be administered as ordered. Review of Resident #58's medical record revealed, in part, Resident #58 was admitted to the facility on [DATE] with diagnoses of, in part, Parkinson's disease (a progressive brain disorder which affects the body's movements) with anxiety. Review of Resident #58's May 2025 physician's orders revealed, in part, an order for Sinemet (a medication used to treat Parkinson's disease) 25-100 mg 1 tablet by mouth three times a day. Review of Resident #58's May's 2025's eMAR revealed, in part, Resident #58's Sinemet 25-100 mg 1 tablet by mouth was not documented as being administered at 10:00PM on the following dates: 05/05/2025 and 05/09/2025. In a telephone interview on 05/21/2025 at 1:07PM, S7LPN indicated she administered Resident #58's Sinement on 05/05/2025 and 05/09/2025 and failed to document administration of the Sinement on the eMAR as required. In an interview on 05/21/2025 at 1:30PM, S1Administrator indicated Resident #58's Sinemet medication was not documented as being administered as ordered on 05/05/2025 and 05/09/2025, and should have been documented.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure a multi-dose bottle of wound cleanser was handled per Infection Control Guidelines between use on residents for 2 (Resident #18, Resident #42) of 2 (Resident #18, Resident #42) sampled residents observed during wound care. Findings: Review of the Center for Disease Control's Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings Module 8 Wound Care Facilitator Guide, dated 01/27/2023 revealed, in part, multi-dose topical wound care medications, such as sprays, should be dedicated to an individual resident, whenever possible. Further review revealed dedicated containers should have been properly labeled and stored in a manner to prevent cross-contamination or use on another patient/resident. Further review revealed if it was not possible to dedicate an entire tube or container of wound care cream or ointment to an individual patient/resident, then a small amount of medication should have been allocated for single-resident use prior to the procedure. Further review revealed the remainder of the multi-dose container should have been properly stored in a dedicated clean area. Further review revealed containers entering resident care areas should have been dedicated for single-resident use or discarded after use. Observation on 05/20/2025 at 10:29AM revealed S3Registered Nurse/Treatment Nurse (RN/TN) held a bottle of wound cleanser approximately 0.5 inch (in) to 1 in away from Resident #42's left shin wound and then proceeded to spray the wound cleanser directly on Resident #42's left shin wound four times. Further observation revealed after finishing Resident #42's left shin wound care, S3RN/TN walked out the room and placed the bottle of wound cleanser directly on top of her treatment cart, and then placed the bottle of wound cleanser into the bottom draw of her treatment cart without disinfecting the bottle or putting the bottle into a bag/container to prevent cross contamination. Observation on 05/20/2025 at 10:40AM revealed S3RN/TN removed the wound cleanser bottle used in the above mentioned observation without disinfecting the bottle and then entered Resident #18's room. S3RN/TN then proceeded to spray the wound cleanser 0.5 in to 1 in from Resident #18's left first metatarsophalangeal joint (joint at the bottom of the big toe) wound and then sprayed the wound cleanser directly on Resident #18's left first metatarsophalangeal joint wound two times. Further observation revealed after finishing Resident #18's left first metatarsophalangeal joint wound care, S3RN/TN walked out the room and placed the bottle of wound cleanser directly on top of her treatment cart, and then placed the bottle of wound cleanser into the bottom draw of her treatment cart without disinfecting the bottle or putting the bottle into a bag/container to prevent cross contamination. In an interview on 05/20/2025 at 10:48AM, S3RN/TN confirmed she had used the same bottle of wound cleanser to perform both Resident #18 and Resident #42's wound care. S3RN/TN acknowledged she had sprayed wound cleanser directly from the bottle onto Resident #42 and Resident #18's wounds and then put the bottle of wound cleanser back into the treatment cart without sanitizing between resident uses. In an interview on 05/20/2025 at 11:33AM, S2Director of Nursing indicated S3RN/TN should not have sprayed the wound cleanser directly onto the Resident #18 and Resident #42's wounds.