STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555134	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Miguel Covenant Village	325 Kempton St. Spring Valley, CA 91977

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 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** 47466 Based on observation, interview and record review, the facility failed to ensure Resident 1 was free from physical restraint when Licensed Nurse (LN) 1, placed a bed linen (flat sheet) from the Resident ' s shoulders to her waistline. In addition, both sides of the bed linen were tucked under the mattress. This bed linen was used to prevent Resident 1 from pulling her foley catheter (a flexible tube that drains urine from the bladder). This deficient practice had the potential for Resident 1 to not move freely and possible choking, serious injury or death. Findings: The Department received a facility reported incident (FRI) related to possible restraint being used to Resident 1 on 10/28/24. An unannounced visit to the facility was conducted on 11/12/24. A record review of the facility ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses to include Pelvis Dementia (type of memory loss with pelvic injury) and Osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). An interview on 11/12/24 at 1 P.M., with the Certified Nursing Assistant (CNA) CNA 1 was conducted. CNA 1 stated the incident happened in the evening shift on 10/28/24 between 8:30 P.M. and 9 P.M. while working with LN 1. CNA 1 stated Resident 1 had been pulling her foley catheter. LN 1 stated to CNA 1 that the flat sheet would prevent Resident 1 from pulling her foley catheter. CNA 1 stated the flat sheet was placed from the Resident ' s shoulders to waistline and tucked on both sides of the sheet under the mattress. CNA 1 stated she worked double shift from PM shift to NOC (night shift- 11 P.M - 7 A.M.), and Resident 1 was observed asleep throughout the night until her shift ended at 7A.M. on 10/29/24. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview on 11/14/24 at 1:18 P.M., with LN 1 was conducted. LN 1 stated, Resident 1 was very confused and aggressive, and pulled out her foley catheter that evening so LN 1 placed a flat sheet below her chest, tucked both sides of the sheet under the mattress and placed the sheet across Resident 1 ' s chest to prevent from pulling her foley catheter again and hurting herself. LN 1 further stated he thought it was right to put a flat sheet over Resident 1 because it was only a flat (soft) sheet and not something like metallic or chain-like. A record review of Resident1 ' s Minimum data set (MDS- a federally mandated assessment tool) dated 8/28/24 indicated a BIMS (brief interview for mental status) score of 0 out of 15 which meant Resident 1 ' s cognition was severely impaired. A record review of Resident 1 ' s History and Physical record dated 5/23/24 indicated Resident 1 does not have the capacity to understand and make her own decisions. A record review of Resident 1 ' s Physician ' s order sheet dated 11/24 did not have an order for any type of physical restraint. A review of Resident 1 ' s medical record did not indicate any consent from Resident 1 ' s family for a restraint use. A record review of Resident 1 ' s care plan did not indicate a physical restraint care plan. There was no documented evidence to indicate the physician was notified before applying the sheet across Resident 1. A phone interview on 11/15/24 at 3:42 P.M., with LN 2 was conducted. LN 2 stated CNA 2 called him and showed underneath Resident 1 ' s blanket. LN 2 stated a flat sheet wedge and rolled up (strap size) across Resident 1 ' s shoulders and chest area with both sides of the sheets wedged under the mattress were observed. LN 2 asked CNA 2 to call the Director of Nursing (DON). A phone interview on 11/15/24 at 3:42 P.M., with LN 2 was conducted. LN 2 stated CNA 2 called him and showed the flat sheet underneath Resident 1 ' s blanket. LN 2 stated a flat sheet wedge and rolled up (strap size) across Resident 1 ' s shoulders and chest area with both sides of the sheets wedged under the mattress were observed. LN 2 asked CNA 2 to call the Director of Nursing (DON). A phone interview on 11/15/24 at 4 P.M., with the DON was conducted. The DON stated on 10/29/24 at around 8:00 A.M., LN 2 called and notified her and asked her to assess Resident 1. The DON stated she took a picture of Resident 1 while she was in bed with a flat sheet over her chest area. The DON stated a restraint was applied to Resident 1. The DON stated it was not permitted in the facility to have any resident on restraints unless necessary. The DON stated a Physician ' s order and a consent from the responsible party was required before a restraint was applied to Resident 1. The DON stated Resident 1 did not have a physician order for restraint. The DON further stated it was important to not have any resident on any type of restraint chemical or physical to prevent injury or health decline. The DON stated she spoke to LN 1 who was working that evening and stated he intentionally applied the flat sheet to keep Resident 1 from pulling her foley catheter. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview on 11/18/24 at 1:06 P.M., with CNA 2 was conducted. CNA 2 stated on 10/29/24 at 6:30 A. M. when she came in, she saw Resident 1 lying in bed covered with a blanket. CNA 2 stated an hour after (7:30 A.M.), CNA 2 went back to Resident 1 ' s room to provide care. CNA 2 stated she uncovered Resident 1 ' s blanket and saw the folded flat sheet tucked on both sides under Resident 1 ' s mattress. CNA 2 took off one side of the folded white sheet underneath the mattress, then called LN 2 and the DON. A phone interview on 11/22/24 at 9:36 A.M., with the DON was conducted. The DON stated, We have included the facility policy on Abuse Prevention that included misuse of restraints. A review of the Nursing Home Resident Rights indicated Your Right to be Free from Restraints As a resident in a nursing home, you have the right to be free from physical and chemical restraints . A review of the facility policy titled Abuse Prevention dated 10/22 .misuse of restraints- Chemical or physical control of a resident beyond the physician ' s orders or not in accordance with the resident ' s plan of care . includes any physical or mechanical device, material, or equipment attached or adjacent to the resident ' s body that the resident cannot remove easily that restricts freedom of movement or normal access to ones ' body .