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	08/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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	08/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to prevent 1 of 3 sampled residents (Resident 1) from falling, when Resident 1 was not provided with adequate supervision and appropriate support to prevent an accident. As a result, Resident 1 fell out of bed, sustaining a left finger fracture and subsequent infection. Findings: A review of Resident 1's undated Face Sheet indicated that the resident was admitted to the facility 3/28/25, with diagnoses that included encephalopathy (damage or disease that affects the brain) and dementia (decline in mental ability). An interview with the Director of Nursing (DON) was conducted on 7/17/25 at 10:33 A.M. The Director of Nursing (DON) stated Resident 1 had an unwitnessed fall on 7/8/25. According to the DON, while CNA 1 and a SNA were changing Resident 1, the wife of Resident 1's roommate informed CNA 1 that her husband was vomiting and needed help. The DON stated CNA 1 left Resident 1's room to get the nurse, leaving Resident 1 alone with the SNA. The DON stated when CNA 1 returned to Resident 1's room with the nurse, Resident 1 was on the floor by the bed. According to the DON, the SNA stated she had turned her back to get gloves when the resident fell on the floor. The DON stated Resident 1 was visibly bleeding, but awake and responsive. The DON stated Resident 1 was transported to the hospital, had a Computed Tomography (CT-a computerized x-ray) of the head and repair of a laceration (a cut to the skin) on the resident's left 4th finger. According to the DON, Resident 1's left finger was not x-rayed while at the hospital and the resident returned to the facility the same day (7/8/25). The DON stated that on 7/12/25, a nurse observed Resident 1's left 4th finger was red, swollen and warm to touch. According to the DON, the physician was notified and an x-ray of Resident 1's left hand was completed which showed a fracture (break) of the left 4th finger. The DON stated Resident 1 was sent to the hospital and was admitted with diagnoses of cellulitis (a deep skin infection caused by bacteria) and fracture of the left 4th distal phalanx (finger bone). According to the DON, Resident 1 had not returned to the facility. The DON further stated that CNAs need to ensure that a resident was safe before leaving the room and not to leave the student alone with a resident. A review of Resident 1's Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents), dated 7/3/25, indicated that Resident 1 had severely impaired cognitive skills (a significant decline in mental abilities that profoundly impacts a person's daily life and ability to live independently). The MDS also indicated Resident 1 was non-ambulatory and dependent on staff for Activities of Daily Living (ADLs). A review of Resident 1's Interdisciplinary Team (IDT-a group of professionals from different disciplines that work together) note regarding the fall, dated 7/11/25, indicated, Resident was left unattended, possibly without appropriate support.Bed not in lowest position. The note further indicated, Remind staff not to leave resident unattended during brief changes. Ensure staff remains with the resident throughout the process of incontinence (lack of voluntary control of bladder or bowel function) care. Before leaving the patient make sure bed is on lowest position. A review of Resident 1's Clinical Notes documented by the Charge Nurse (CN), dated 7/8/25, indicated that the CN went to Resident 1's room to assess the resident after the unwitnessed fall. The CN documented that Resident 1 had hit the left side of his head and sustained a bleeding laceration. The CN also documented that Resident 1 was on blood thinner medications. The Clinical Note indicated that Resident 1's bed was raised and the bed rails were not in place. A review of Resident 1's Clinical Notes, dated 7/12/25, indicated that Resident 1's left 4th finger was very red, swollen, warm to touch. The Clinical Note indicated an x-ray of Resident 1's left hand was conducted at the facility which showed an acute comminuted fracture (where the bone breaks into three or more pieces) of the fourth distal phalanx, with associated soft tissue swelling. The Clinical Note indicated Resident 1 was sent to the hospital and was admitted with an infection of the left fourth finger and left upper extremity cellulitis (infection of left upper arm). An interview with CNA 1 was conducted on 8/12/25 at 10:14 A.M. CNA 1 stated that he and the SNA were changing Resident 1 when the roommate's wife yelled out that her husband was vomiting. CNA 1 stated he immediately went to get the nurse and when they returned, Resident 1 had fallen out of bed. CNA 1 stated Resident 1's bed was set in a high position because they were in the middle of changing him. CNA 1 acknowledged that the SNA should not be left alone with the resident, and stated In this event, I should've sent her out instead of myself to reach out for the nurse. On 8/12/25 at 4:06 P.M. the SNA stated during an interview that she and CNA 1 were changing Resident 1 when the roommate's wife yelled out to get a nurse because her husband was throwing up. CNA 1 then rushed out to get the nurse, but as soon as he left, the resident turned and fell to the ground. The SNA stated that Resident 1 tended to reach for the siderails, which were down at the time. The SNA further stated, It