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	08/07/2025

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide Range of Motion (ROM-the extent or limit to which a body part can be moved; the totality of movement a joint is capable of doing. ROM is gauged as passive PROM {needs assistance} or AROM {independent}, exercises for three of four residents .(7, 52, 78), reviewed for Mobility and Positioning. This failure had the potential for Residents 7, 52, and 78 to have a reduction in mobility and flexibility, causing them to become more dependent on staff for activities of daily living. (Cross Reference F641)Findings: 1. Resident 7 was admitted to the facility on [DATE], with diagnoses which included cerebral palsy (a brain disorder that affects movement, balance, and posture), per the facility's admission Record. An observation and interview was conducted with Resident 7 on 08/4/25 at 9:07 A.M., in her room. Resident 7 was sitting up in bed, eating breakfast with her left hand. Resident 7's right hand was contracted (a condition of shortening and stiffening of the muscles and tendons, leading to deformity and rigidity of the joints). Resident 7 stated she was getting physical therapy and then restorative nursing assistance (RNA- a specialized Certified Nursing Assistant (CNA) who focuses on helping patients regain or maintain their highest possible level of physical function by focusing on physical rehabilitation with body movements and strengthening by utilizing passive ROM), but they stopped about a year ago. Resident 7 stated she was told her insurance no longer covered the ROM/RNA services. Resident 7 stated she would like to have the ROM services again, because it helped with her contractures, and she believed her right hand has worsened since they stopped the service. Resident 7's medical record was reviewed on 8/5/25: According to the Minimum Data Set (MDS-a clinical assessment tool), dated 7/15/25, Resident 7 had a cognitive score of 13, indicating cognition was intact. The Functional Abilities section indicated impairment on one side of the body and complete impairment to the lower extremities with a wheelchair being required when out of bed. The Special Treatments, Procedures, and Programs section had no indication of physical therapy or ROM services being provided. According to the physician orders, dated 2/3/20, Resident 7 was to receive physical therapy, five times a week for two weeks. There were no additional orders for physical therapy or RNA services after the 2/3/20 order. According to the care plan, titled ADL (activities of daily living) deficit related to cerebral palsy, functional paraplegia, revised 11/7/24, list a goal of having Resident 7 maintain her independence of (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs. Interventions listed included PT eval for increased weakness, PT to evaluate for electric wheelchair, allow resident to complete as much of her task as possible. According to the last quarterly care conference, dated 3/19/25, the physical therapy section was blank, with no mention of providing RNA services to prevent worsening contractures. An interview and record review was conducted with Restorative Nursing Assistant 1 (RNA 1 on 8/6/25 at 7:41 A.M. RNA 1 stated the facility had two RNAs daily. One RNA provided cycling, and the other RNA provided ROM to residents. RNA 1 stated they charted daily for the RNA services provided to residents, and they also had monthly meetings with the Director of Rehabilitation (DOR), to discuss the residents treatment plans. RNA 1 stated it was important for staff to identify a decline in residents ROM's, so early interventions could be implemented. The RNA stated if there was an identified decline, the DOR or physician would write an order for physical therapy or RNA services. RNA 1 stated the facility has an unwritten policy that if a resident declines RNA services three times in a row, then they would be dropped from the RNA program. RNA 1 continued, stating Resident 7 was receiving RNA services, but was dropped about a year ago, because she refused the service when she returned from the hospital. RNA 1 stated she was unaware if anyone had reapproached Resident 7 to see if she wanted to resume RNA services. RNA 1 stated RNA was important for Resident 7 because of her disease process. RNA 1 provided copies of Resident 7's daily RNA notes. The first RNA treatment started on 1/9/24. The last four handwritten entries read: 7/21/24-Resident refused not feeling well. 7/25/24-Resident refused. Not feeling well. 7/30/24-Resident refused, c/o of too much hip and knee pain. Charge nurse notified. 8/1/24-Residetn refused, c/o too much hip and knee. Charge nurse notified. There was no documented evidence that Resident 7 was reapproached to see if she was feeling better or wanted to resume RNA service. 2. Resident 52 was admitted to the facility on [DATE], with diagnoses which include polyneuropathy (a malfunction of many peripheral nerves throughout the body), per the facility's admission Record. An observation and interview was conducted with Resident 52 on 8/4/25 at 9:14 A.M., in her room. Resident 52 was sitting up in bed, working on an tablet with her left hand, which was severely contracted, with only the middle finger extended. A brace was on her right hand. Resident 52 stated she was getting physical therapy before, but it stopped because of her insurance. Resident 52 stated since the physical therapy stopped, she was getting RNA services, but that stopped too about two months ago, after her insurance ran out. Resident 52 stated she would like to have the RNA services back, because she felt it helped her a lot. Resident 52 stated she was supposed to wear a brace on her left hand, but then she would not be able to do anything independently, like to use her tablet, or to eat. Resident 52 stated she used to have a wound on her left leg, but it has since healed up. On 8/5/25, Resident 52's medical record was reviewed: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS, dated [DATE], Resident 52 had a cognitive score of 15, indicating cognition was intact. According to the Functional Abilities assessment, there were no changes in the ROM over the past 7 day look-back period. According to the physician orders, dated 8/4/25 at 3:48 P.M., an order for ROM exercises was added, “…three times a week for three sets x10 reps in all planes, as tolerated.” According to the care plan, ADL deficit related to lack of coordination, dated 9/30/21, listed a goal of Resident 52 achieving greater independence. Interventions included, Allow adequate time to eat and complete task, set-up and provide assistance, PT/OT evaluation, bilateral upper and lower extremities range of motion exercises, and apply hand splints as ordered According to the care conference dated 6/26/25, RNA was checked for receiving services three times a week. An interview and record review was conducted with RNA 1 on 8/6/25 at 7:41 A.M. RNA 1 stated Resident 52 used to receive RNA services, but she developed a wound on her leg and started to refuse because of the pain. RNA 1 stated she as not sure when Resident 52's RNA stopped, but it was probably about a month ago. RNA 1 stated the resident asked yesterday if she could start RNA again, so they approached her to discuss it. RNA 1 provided the daily RNA notes for Resident 52. The earliest RNA note started on 3/9/25. The last three handwritten entries read: 6/9/25-Resident refused. Complained of pain on the right leg. Encouraged x3 but still refused. Charge nurse aware. 6/13/25-Active Range of motion refused c/o of pain on right leg. Encouraged x 3, but still refused. 6/14/2-Resident refused. Complained of right knee pain. Encouraged x3 but still refused. Charge nurse aware. There was no documented evidence that Resident 7 was reapproached to see if she was feeling better or wanted to resume RNA service. An interview was conducted with Charge Licensed Nurse 1 (Chg LN 1) on 8/6/25 at 8:09 A.M. Chg LN 1 stated the goal was to have residents maintain or improve their range of motion, and to never have them decline. Chg LN 1 stated ROM maintains independence and prevents further illness or decreased movement. Chg LN 1 states he depends on certified nursing assistants (CNAs) to identify resident who were declining in ROM and to inform him. Chg LN 1 stated he also assessed residents during his weekly evaluations for declines. Chg LN 1 stated if a decline was identified, the DOR should be contacted to evaluate the resident and then communicate their assessment to the physician, to see what services should be implemented. Chg LN 1 stated if a resident repeatedly refused RNA it should be documented and then a care conference should be conducted, to determine the reason for the refusal, so modifications could be made, Chg LN 1 stated if a Resident repeatedly refused RNA, and was dropped from the RNA program, someone should be reapproaching them monthly, to see if they wanted to resume the services. Chg LN 1 stated he would expect to see documentation of the care conference, why refused, when reapproached, and what the response was, along with the risk and benefits being explained to the residents. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up interview was conducted with Resident 52 on 8/6/25 at 8:31 A.M., in her room. Resident 52 stated after the previous days' interview, she had realized she really wanted to have RNA services again, so she asked staff and they said someone would come talk to her about it. Resident 52 stated they had not started the RNA back up yet An interview and record review was conducted with the DOR on 8/6/25 at 8:38 A.M. The DOR stated the purpose of RNA was for residents to maintain range of motion, strength, and activities of daily living. The DOR stated RNA staff wrote daily notes, and they discuss residents during their monthly team meetings. The DOR stated they also discussed resident issues during their daily stand-up meetings each morning. The DOR stated she did not attend care conference for custodial residents (long term residents with no plans to discharge) or residents placed on hospice. The DOR stated she set a policy that if RNA services were refused three consecutive times, then RNA services would be cancelled. The DOR stated she personally spoke with the residents who refused RNA services and she ensured that it was documented why they were refusing. The DOR stated RNA would never be discontinued because of insurance reasons. The DOR stated she accompanied the Minimum Data Set Nurse (MDSN) with conduct Grand Rounds every Friday. The DOR stated Grand Rounds were one to ones with residents, to ensure their conditions were not declining without staff intervention. The DOR stated the MDSN keeps notes on what residents said or if they refused offered services. The DOR stated Resident 7 finished her physical therapy on 4/9/25, but she still had a wound, so RNA services were refused and had not yet been reinstated. The DOR stated she just saw Resident 52 on 8/5/25, after she had learned the resident asked to re-start RNA. THE DOR stated if someone was dropped from RNA for refusing, then the hope was they could be offered it again during the Grand Rounds. An interview and record review was conducted with the MDSN on 8/6/25 at 9:05 A.M. The MDSN stated the purpose of Grand Rounds was if there were any changes in the resident's condition, early interventions could be implemented. The MDSN stated they do hallway sections every Friday and she documented any issues identified. The MDSN reviewed her notes for Grand Rounds, stating Resident 7 was last seen May 2025. The MDSN stated she did not have any notes for Resident 7 and she did not recall Resident 7 saying anything about RNA. The MDSN stated she knew the DOR asked that standard question for every visit about RNA and ROM. The MDSN stated she did not know what Resident 7's reply was, because there were no notes documented for that visit. The MDSN stated Resident 52's Grand Round was also in May 2025, and no notes were made for the room visit. The MDSN stated it should be documented each visit that RNA was offered, and the risk and benefits were explained. The MDSN stated by not asking and documenting the residents' response to RNA, there was a potential for decline in mobility, which could affect everyday function and independence. The MDSN stated it would be important for her to be told when the RNA services were discontinued, so she could follow up on that during the Grand Rounds. An interview was conducted with the Director of Nursing (DON on 8/7/25 at 10:49 A.M. The DON stated RNA services were important to prevent a decline or worsening of movement. mobility. The DON stated the facility needs to reassess the RNA system, so improvement could be made. According to the facility's policy titled, Resident Mobility and Range of Motion, dated July 2017, :…2. Resident with limited range of motion will receive treatment and services to increase and or prevent a further decrease in ROM…” 3. A review of Resident 78's admission Record indicated Resident 78 was admitted to the facility on (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] with diagnoses which included a history of Rheumatoid Arthritis (a long-term condition that causes pain, swelling and stiffness in the joints). A record review of Resident 78's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/14/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 11 points out of 15 possible points which indicated Resident 78 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 8/5/2025 at 8:22 A.M., an observation was conducted in Resident 78's room. Resident 78 was being fed by Certified Nursing Assistant (CNA) 28 wearing a personal protective equipment (PPE) gown. CNA 28 stated Resident 78 needed help with feeding due to her hand contractures then left Resident 78 to go to the dining room. Resident 78's breakfast tray was untouched after CNA 28 left the room. On 8/5/2025 at 8:43 A.M., an observation was conducted in Resident 78's room. CNA 28 returned to Resident 78's room and placed a spoon on Resident 78's right hand then left. 08/05/2025 9:01 AM an observation and interview was conducted with Resident 78, in Resident 78's room. Resident 78 stated she had pain in both her hands and left shoulder due to contractures. Resident 78 stated she required assistance with all her activities of daily living (ADL-dressing, eating, toileting, and transfers) because mobility was limited by the pain in both her hands and shoulders. Resident 78 stated she was unable to stretch both her arms and hands out fully without staff assistance. Resident 78 stated she does not do ROM exercises with staff for her upper extremities (UE- arms and shoulders) but would like to benefit from ROM exercises for mobility to help relieve pain in her hands and shoulders when performing ADLS. On 8/5/2025 at 1:32 P.M., an interview was conducted with CNA 27. CNA 27 stated Resident 78 had contractures on both hands and that they were not new contractures. CNA 27 stated that Restorative Nursing Assistants (RNA) do ROM exercises with facility residents and was not sure if Resident 78 was on an RNA program for her bilateral hand contractures. On 8/5/2025 at 1:42 P.M., an interview was conducted with RNA 1. RNA 1 stated Resident 78 used to be on an RNA program but was on hospice now as to why Resident 78's RNA program did not continue. RNA 1 stated Resident 78 had bilateral hand contractures that were not new. RNA 1 stated that Resident 78 does have limited ROM on her left shoulder and both of her hands that would limit her abilities to perform ADLS independently and needed assistance. RNA 1 stated with the lack of ROM exercises to be performed with Resident 78 could contribute to a decline in mobility. On 8/5/2025 at 1:44 P.M., an interview with CNA 22 was conducted. CNA 22 stated Resident 78 was on and off RNA program but then Resident 78 got sick. CNA 22 stated it was important for Resident 78 to receive regular ROM exercises for her arms and hands to prevent further stiffness and pain. CNA 22 stated without ROM, Resident 78's contractures could worsen, causing increased discomfort, limiting Resident 78's mobility and making it harder for her to perform daily activities such as eating, dressing, and personal care. CNA 22 further stated Resident 78 already experienced pain in her left shoulder and hand contractures which could increase if no interventions were provided. On 8/5/2025 2:00 P.M., an interview and record review was conducted with Physical Therapy (PT) 1. PT 1 stated Resident 78's last rehab evaluation was on 3/26/25 for her range of motion. The rehab (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evaluation indicated: “…UE [upper extremities] ROM LUE [left upper extremities]= impaired, RUE [right upper extremities]= impaired…RUE ROM Shoulder = Impaired (severe ROM deficits with crepitus [crackling sound] throughout, unable to demo [demonstrate] full ROM via PROM [passive range of motion]); Elbow /Forearm = Impaired (severe ROM deficits with crepitus throughout); Wrist = Impaired (severe ROM deficits in hand/forearm/wrist with crepitus throughout) LUE ROM Shoulder = WFL; Elbow / Forearm = WFL; Wrist = Impaired (severe ROM deficits in hand/forearm/wrist with crepitus throughout) LUE Strength LUE Strength = DNT; Clinical Reason(s) = Presence of lines/tubes RUE Strength RUE Strength = DNT; Clinical Reason(s) = Severe pain…” “…Pt [Patient] presents during OT [Occupational Therapy] evaluation with severe ROM deficits in BUE…deficits in strength and pt is primarily bedbound. Pt is at baseline and benefits from RNA program for BUE/BLE ROM to prevent further contractures…” On 8/5/2025 at 2:07 P.M., an interview and record review was conducted with the Director of Rehab (DOR). The DOR stated Resident 78 was getting RNA for her BUE (bilateral upper extremities) for impaired ROM. The DOR stated Resident 78 transitioned to hospice services (4/3/25) and was removed from the RNA program because “she was not doing good and family elected not to do hospice services at that time.” On 8/5/2025 2:35 P.M., an interview was conducted with the DOR. The DOR stated she was unable to find documentation that the RNA program was discussed with the family refusing to continue the RNA program. The DOR that Resident 78 would benefit from participation in an RNA program to help reduce pain sensitivity, improve pain-free ROM, and prevent further injury. The DOR stated that regular exercise, when tailored to Resident 78's needs, is essential to maintaining function and enhancing quality of life. On 8/5/2025 at 2:29 P.M., an interview and record review was conducted with the MDS nurse (MDSN). The MDSN. The MDSN nurse stated rehab should be involved in the care of all residents, including those on hospice, to ensure they are assessed for and receive services that maintain or improve function. The MDSN stated this involvement with rehab could help increase independence, reduce pain, prevent injuries and support a more personalized plan of care for Resident 78's needs. A clinical chart review of Resident 78's active care plan indicated, “…ADL Deficit related to deconditioning from recent illness, weakness, CHF [congestive heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling] .under the care of [Name of Hospice]…At risk for falls/ fall related injury related to impaired mobility, impaired balance .Self-feeding difficulty related to arthritis in hands as evidenced by residents fingers appearing deformed.” Care plan interventions included: - “…Eating set up - Oral hygiene partial assist - Toileting hygiene dependent - Showering dependent (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Upper body dressing substantial [helper provides more than half of the effort] assist - Lower body dressing dependent - Putting on/off footwear dependent - BUE/BLE PROM [passive range of motion] 3x/wk [three times per week] x [times] 15min [minutes] Slow gentle ROM to tolerance - AAROM [active range of motion] of LUE 3x/wk as tolerated PROM of BUE and RUE as tolerated Please do gentle PROM to pt tolerance. If pt unable to tolerate, let OT know.…” 8/6/2025 at 8:32 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the licensed nurses (LN) do not complete quarterly assessments. The ADON stated the MDSN is responsible for performing these assessments and representing the nursing side during interdisciplinary (IDT) meetings and providing recommendations for rehab screens when appropriate. The ADON stated it would be beneficial for Resident 78 to participate with an RNA program to provide regular exercise, ROM interventions that would be essential to help Resident 78 maintain her ability to perform ADLs to prevent avoidable decline, reduce stiffness, alleviate pain and promote flexibility. The ADON further stated these interventions are necessary to maintain or improve function and enhance Resident 78's quality of life. 08/06/2025 4:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for Resident 78 to be properly screened regardless of Hospice status for RNA. The DON stated the MDSN should be physically assessing Resident 78 during a quarterly review, bring findings to the IDT meeting, and provide recommendations for care, including mobility concerns. The DON stated participation with an RNA program would have been beneficial for Resident 78, especially given her contractures, to prevent avoidable decline in ADLs and injuries. The DON further stated regular ROM exercises help prevent worsening of contractures, maintain stability, reduce pain, and improve quality of life and should not be limited to residents (all facility residents) hospice status. A review of the facility's policy and procedure titled RESTORATIVE NURSING SERVICES revised July 2017, indicated, “…Residents may be started on a restorative nursing program upon admission, during the course or stay or when discharged from rehabilitative care…”

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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, interview, and record review, the facility failed to practice safe food handling practices in the kitchen when:1. Hot dogs were not discarded by the discard date,2. Bread pudding was not covered before placing in the refrigerator, and3. A hair net was not worn by the cook, and4. Hand washing and glove changes were not made after touching contaminated surfaces during tray line.These failures had the potential for residents to be exposed to food borne illness. Findings:1. During an initial tour of the kitchen, an observation was conducted on 8/4/25 at 8:04 A.M., of one kitchen freezer (labeled #4) with the Registered Dietitian (RD). On the left side of the freezer, on the second shelf was a clear sealed plastic bag containing eight hot dogs. The clear plastic bag was labeled with a discard date of 7/24/25. An interview was conducted with the RD on 8/4/25 at 8:06 A.M. The RD stated the hot dogs should have been thrown away on or before the discard date. The RD stated if the hot dogs were served, they could have caused food borne illness to whoever ate them.According to the facility's policy, titled Sanitation & Infection Control, Labeling & Dating; dated January 2016, .All foods are labeled, dated, .and use-by dates are monitored and followed.2. During an initial tour of the kitchen, an observation and interview was conducted on 8/4/25 at 8:09 A.M., for one of four refrigerators (labeled #2) with the RD. A large shallow tray was on the right side of the refrigerator, on the third shelf. The food product (bread pudding) was uncovered and exposed to elements within the refrigerator. The RD stated the tray contained, Bread pudding which was being served for lunch today. The RD stated the pudding should have been covered in plastic wrap to protect it. The RD stated the pudding could cause food borne illness to residents if not covered and protected.According to the facility's policy, titled Sanitation & Infection Control, Labeling & Dating; dated January 2016, .All foods are labeled, dated, and securely covered.3. During a follow-up visit to the kitchen on 8/6/25 at 10:17 A.M., an observation was conducted of [NAME] 3 (CK 3). CK 3 was observed putting large food pans in the food warmer. CK 3 was wearing a baseball cap with no hair net. CK 3 had dark black hair down to the collar and sideburns. An interview was conducted with CK 3 on 8/06/25 at 10:18 A.M. CK 3 stated when he entered the kitchen, he should have put on a hair net. CK 3 stated without a hairnet, food could fall into the food, and cause residents to get sick. An interview was conducted with the kitchen's Dietary Staff Supervisor (DSS) on 8/6/25 at 10:19 A.M. The DSS stated she thought if staff wore hats, it was acceptable. The DSS stated CK 3 had hair to his collar and stated the hair could fall out into resident food, which could cause illness to the residents.An interview was conducted with the RD on 8/06/25 at 12:05 P.M. The RD stated all kitchen staff needed to wear hair nets and wearing just a hat was not acceptable. The RD stated that without a hairnet, hair could fall onto food and kitchen surfaces, which could cause residents to become ill. According to the facility's policy, titled Food Safety Management System, dated May 2025, .Food employees must wear hair restraints.4. An observation was conducted on 8/6/25 at 11:59 A.M. during lunch tray line. CK 3 was observed wearing disposable gloves and serving food. CK 3 removed clear cellophane from a plate that contained a large slice of pizza. CK 3 grabbed a lower cabinet handle with his right-gloved hand and disposed of the cellophane wrap in a trashcan. CK then closed the cabinet door with his right-gloved hand. CK 3 did not remove his gloves or wash his hands and resumed serving food.An additional observation of CK 3 was conducted on 8/6/25 at 12:01 P.M. during lunch tray line. An unknown Licensed Nurse (LN) informed CK 3 that a resident wanted carrots instead of brussels sprouts. CK 3 was observed opening a lower cabinet drawer by the handle, with his right gloved hand and removed a serving spoon. CK 3 closed the cabinet drawer with his stomach and proceeded to serve carrots on a plate with the serving spoon. CK 3 did not remove his gloves or wash his hands before resuming food service.An additional observation of CK 3 was conducted on 8/6/25 at 12:02 P.M., during lunch tray line. CK 3 was observed removing toast from the toaster behind him, with his left hand. CK 3 then opened a lower cabinet drawer by the handle with his right (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand and removed a plate. CK 3 placed the toast on the plate and closed the cabinet door with his right hand. CK 3 resumed tray line service without removing his gloves and washing his hands. CK 3 was never observed removing his original gloves or washing his hands throughout tray line service.An interview was conducted with the RD on 8/06/25 at 12:05 P.M. The RD stated she expected kitchen staff to remove their gloves and wash their hands after touching anything other than food, such as contaminated objects or surfaces. The RD stated all residents had the potential for food borne illness, when safe food practices were not being followed.An interview was conducted with the Director of Nursing (DON) on 8/7/2025 at 10:49 A.M. The DON stated she expected the kitchen to always be clean and sanitary, and to prevent food borne illness from occurring.According to the facility's policy, titled Guidelines for Safe Food Handling Practices, Dated July 2017, .Handwashing/Cross contamination: Thoroughly wash your hands.before and after handling food, touching your face or hair.Do not cross-contaminate.

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Mount Miguel Covenant Village	325 Kempton St. Spring Valley, CA 91977

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dignified and person-centered feeding assistance with certified nursing assistants (CNA) observed feeding residents while standing instead of sitting at eye level for two of eight reviewed residents (Resident 60 and 64) who required assistance.This deficient practice placed two residents (Resident 60 and 64) at risk for loss of dignity, reduced quality of mealtime experience, and potential difficulty or discomfort during mealtimes.Findings:1. A review of Resident 60's admission Record indicated Resident 60 was re-admitted to the facility on [DATE] with diagnoses which included a history of dementia (a progressive state of decline in mental abilities).A record review of Resident 60's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/30/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of three points out of 15 possible points which indicated Resident 60 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. A review of a facility provided document titled, Best Practices For Compliance Related to Resident Dignity in Skilled Nursing Facilities by The American Health Care Association website: http://www.ahca.org indicated, .Areas of potential non-compliance related to the dining experience may include.Staff standing over residents as they are assisted with dining.On 8/5/2025 at 8:20 A.M., an observation was conducted in Resident 60's room. CNA 26 was seen standing over Resident 60 while assisting her with her breakfast tray.On 8/5/2025 at 8:25 A.M., an observation and interview was conducted with the Assistant Director of Nursing (ADON), in Resident 60's room. The ADON stated CNA 26 should not be standing because it was inappropriate while feeding Resident 60 and can be intimidating for Resident 60 because standing can be seen as an authoritative manner and does not promote a good mealtime experience. The ADON stated sitting at an eye level promotes dignity and respect for Resident 60.On 8/6/2025 at 3:57 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that CNA 26 to be at an eye level while feeding Resident 60 to promote a comfortable mealtime experience that was dignified and respectful. The DON further stated sitting at an eye-level while feeding a resident also promotes interaction and assures a quality eating experience without problems.2. A review of Resident 64's admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses which included a history of (a disease characterized by a progressive decline in mental abilities).A record review of Resident 64's MDS (Minimum data set: nursing facility assessment tool) dated 5/20/25 indicated that Resident 64 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.A review of a facility provided document titled, Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities by The American Health Care Association website: http://www.ahca.org indicated, .Areas of potential non-compliance related to the dining experience may include.Staff standing over residents as they are assisted with dining.On 8/4/2025 at 12:23 P.M., an observation was conducted in the Valley View Dining room during mealtime. CNA 23 was seen feeding Resident 64 while standing to assist with feeding.On 8/4/2025 at 12:26 P.M., an interview was conducted with CNA 23, outside of the dining room hallway. CNA 23 stated she should have been sitting down while assisting Resident 64 but did not. CNA 23 stated that sitting down at an eye level would make Resident 64 feel more comfortable about her dinning experience and shows dignity and respect. CNA 23 stated standing while feeding Resident 64 would make her feel confused and a dignity issue as to why I would be standing up. CNA 23 stated sitting at an eye-level with a resident helps to initiate conversation and safety to monitor potential choking hazards.On 8/4/2025 at 12:35 P.M., an interview was conducted with CNA 21, in the Valley View Dining room. CNA 21stated that (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they (nursing staff) should be feeding residents (any facility residents who need feeding assistance) while sitting promotes respect and dignity.On 8/6/2025 at 3:49 P.M., an interview with the Director of Nursing (DON) stated her expectations was for nursing staff to promote dignity and respect while assisting residents (any facility residents who need feeding assistance) in a dignified manner by sitting at an eye-level to promote an interactive and quality eating experience.The facility did not provide a policy and procedure for Dignity.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately code a hospice resident's limitation in range of motion (ROM) for the upper extremities on the Minimum Data Set (MDS- a federally mandated resident assessment tool) for one of four residents reviewed with hand contractures. As a result, inaccurate information was sent to the federal database and placed Resident 78 at risk for inaccurate care planning and avoidable decline in functional mobility.Cross Reference F688 Findings:Based on observation, interview and record review, the facility failed to accurately code a hospice resident's limitation in range of motion (ROM) for the upper extremities on the Minimum Data Set (MDS- a federally mandated resident assessment tool) for one of four residents reviewed with hand contractures. As a result, inaccurate information was sent to the federal database and placed Resident 78 at risk for inaccurate care planning and avoidable decline in functional mobility.Cross Reference F688Findings:A review of Resident 78's admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses which included a history of Rheumatoid Arthritis (a long-term condition that causes pain, swelling and stiffness in the joints).A record review of Resident 78's Minimum Data Set, dated [DATE] indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 11 points out of 15 possible points which indicated Resident 78 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 8/5/2025 at 8:22 A.M., an observation was conducted in Resident 78's room. Resident 78 was being fed by Certified Nursing Assistant (CNA) 28 wearing a personal protective equipment (PPE) gown. CNA 28 stated Resident 78 needed help with feeding due to her hand contractures then left Resident 78 to go to the dining room. Resident 78's breakfast tray was untouched after CNA 28 left the room.On 8/5/2025 at 8:43 A.M., an observation was conducted in Resident 78's room. CNA 28 returned to Resident 78's room and placed a spoon on Resident 78's right hand then left.08/05/2025 9:01 AM an observation and interview was conducted with Resident 78, in Resident 78's room. Resident 78 stated she had pain in both her hands and left shoulder due to contractures. Resident 78 stated she required assistance with all her activities of daily living (ADL-dressing, eating, toileting, and transfers) because mobility was limited by the pain in both her hands and shoulders. Resident 78 stated she was unable to stretch both her arms and hands out fully without staff assistance. Resident 78 stated she does not do ROM exercises with staff for her upper extremities (UE- arms and shoulders) but would like to benefit from ROM exercises for mobility to help relieve pain in her hands and shoulders when performing ADLS.On 8/5/2025 at 1:32 P.M., an interview was conducted with CNA 27. CNA 27 stated Resident 78 had contractures on both hands and that they were not new contractures. CNA 27 stated that Restorative Nursing Assistants (RNA) do ROM exercises with facility residents and was not sure if Resident 78 was on an RNA program for her bilateral hand contractures.On 8/5/2025 at 1:42 P.M., an interview was conducted with RNA 1. RNA 1 stated Resident 78 used to be on an RNA program but was on hospice now as to why Resident 78's RNA program did not continue. RNA 1 stated Resident 78 had bilateral hand contractures that were not new. RNA 1 stated that Resident 78 does have limited ROM on her left shoulder and both of her hands that would limit her abilities to perform ADLS independently and needed assistance. RNA 1 stated with the lack of ROM exercises to be performed with Resident 78 could contribute to a decline in mobility. On 8/5/2025 at 1:44 P.M., an interview with CNA 22 was conducted. CNA 22 stated Resident 78 was on and off RNA program but then Resident 78 got sick. CNA 22 stated it was important for Resident 78 to receive regular ROM exercises for her arms and hands to prevent further stiffness and pain. CNA 22 stated without ROM, Resident 78's contractures could worsen, causing increased discomfort, limiting Resident 78's mobility and making it harder for her to perform daily activities such as eating, dressing, and personal care. CNA 22 further stated Resident 78 already experienced pain in her left shoulder and hand contractures which could increase (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if no interventions were provided.On 8/5/2025 2:00 P.M., an interview and record review was conducted with Physical Therapy (PT) 1. PT 1 stated Resident 78's last rehab evaluation was on 3/26/25 for her range of motion. The rehab evaluation indicated: .UE [upper extremities] ROM LUE [left upper extremities]= impaired, RUE [right upper extremities]= impaired.RUE ROM Shoulder = Impaired (severe ROM deficits with crepitus [crackling sound] throughout, unable to demo [demonstrate] full ROM via PROM [passive range of motion]); Elbow /Forearm = Impaired (severe ROM deficits with crepitus throughout); Wrist = Impaired (severe ROM deficits in hand/forearm/wrist with crepitus throughout) LUE ROM Shoulder = WFL; Elbow / Forearm = WFL; Wrist = Impaired (severe ROM deficits in hand/forearm/wrist with crepitus throughout) LUE Strength LUE Strength = DNT; Clinical Reason(s) = Presence of lines/tubes RUE Strength RUE Strength = DNT; Clinical Reason(s) = Severe pain.Pt [Patient] presents during OT [Occupational Therapy] evaluation with severe ROM deficits in BUE.deficits in strength and pt is primarily bedbound. Pt is at baseline and benefits from RNA program for BUE/BLE ROM to prevent further contractures.On 8/5/2025 at 2:07 P.M., an interview and record review was conducted with the Director of Rehab (DOR). The DOR stated Resident 78 was getting RNA for her BUE (bilateral upper extremities) for impaired ROM. The DOR stated Resident 78 transitioned to hospice services (4/3/25) and was removed from the RNA program because she was not doing good and family elected not to do hospice services at that time.On 8/5/2025 2:35 P.M., an interview was conducted with the DOR. The DOR stated she was unable to find documentation that the RNA program was discussed with the family refusing to continue the RNA program. The DOR that Resident 78 would benefit from participation in an RNA program to help reduce pain sensitivity, improve pain-free ROM, and prevent further injury. The DOR stated that regular exercise, when tailored to Resident 78's needs, is essential to maintaining function and enhancing quality of life.On 8/5/2025 at 2:29 P.M., an interview and record review was conducted with the MDS nurse (MDSN). The MDSN stated Resident 78 had an overall health decline due to weakness and was also put on hospice on 4/3/25. The MDSN stated she does not remember assessing Resident 78's hands or asked Resident 78 to demonstrate ROM during Resident 78's MDS dated [DATE] time-frame period. A record review of Resident 78's prior MDS indicated:- 2/21/25 Section GG0115 (ROM, UE) was coded as impairment to both sides.- 4/14/25 Section GG0115 (ROM, UE) was coded as no impairment.- 7/14/25 Section GG0115 (ROM, UE) was coded as no impairment.The MDSN stated she had coded inaccurately on Resident 78's MDS on 4/14/25 and 7/14/25. The MDSN stated accurate coding is essential to ensure Resident 78's functional limitations are correctly identified so that Resident 78's plan of care reflects appropriate interventions. The MDSN further stated inaccurate coding can lead to missed services, delayed interventions, and care plans that do not address Resident 78's true needs, placing Resident 78 at risk for avoidable decline and decreased quality of life. There was documentation on Resident 78's clinical chart relating to MDSN, RNA/CNA rounds or interviews that assessed Resident 78's ROM while performing ADLs during the MDS time-frame period on 7/14/25 and 4/14/25. A clinical chart review of Resident 78's active care plan indicated, .ADL Deficit related to deconditioning from recent illness, weakness, CHF [congestive heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling] .under the care of [Name of Hospice].At risk for falls/ fall related injury related to impaired mobility, impaired balance .Self-feeding difficulty related to arthritis in hands as evidenced by residents fingers appearing deformed. Care plan interventions included:- .Eating set up- Oral hygiene partial assist- Toileting hygiene dependent- Showering dependent- Upper body dressing substantial [helper provides more than half of the effort] assist- Lower body dressing dependent- Putting on/off footwear dependent- BUE/BLE PROM [passive range of motion] 3x/wk [three times per week] x [times] 15min [minutes] Slow gentle ROM to tolerance- AAROM [active range of motion] of LUE 3x/wk as tolerated PROM of BUE and RUE as tolerated Please do gentle PROM to pt tolerance. If pt unable to tolerate, let OT [occupational therapy] know.8/6/2025 at 8:32 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed nurses (LN) do not complete quarterly assessments. The ADON stated the MDSN is responsible for performing these assessments and representing the nursing side during interdisciplinary (IDT) meetings and providing recommendations for rehab screens when appropriate. The ADON stated an inaccurate MDS coding could result in needed services (RNA program) to be omitted from Resident 78's plan of care, placing the resident at risk for further functional decline in mobility with ADLs.08/06/2025 4:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for Resident 78 to be properly screened regardless of Hospice status for RNA. The DON stated the MDSN should be physically assessing Resident 78 during a quarterly review, bring findings to the IDT meeting, and provide recommendations for care, including mobility concerns. The DON stated inaccurate MDS coding could result in the omission of these needed interventions (RNA program) from Resident 78's plan of care, placing Resident 78 at risk for further decline and injury.A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page GG-5) GG0115: Functional Limitation in Range of Motion .The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places them at risk of injury

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and treat multiple skin abrasions and scabs for one of one residents reviewed for skin conditions (Resident 35). This failure had the potential to result in delayed provision of care and treatment for Resident 36's skin condition.Findings:Resident 35 was admitted to the facility on [DATE] with diagnoses to include a history of falling, per the Face Sheet. A concurrent observation and interview was conducted with Resident 35 on 8/4/25 at 2:20 P.M. Resident 35 was in bed, with his arms exposed. A large reddened area, approximately two inches wide by six inches wide was visible on his left forearm. A large scab was on Resident 35's right hand, on the webbing between the thumb and index finger. Several more abrasions and bruises were observed along both arms. The skin on both of Resident 35's arms was dry and flaky. A single square dressing, approximately two inches by two inches was hanging loosely from the scab on the right hand. The dressing was loose, with one side adhering to skin and the other three sides unattached. The dressing had the date of 8/1 written on it in black marker, with no other information. Resident 35 stated he had fallen at home, and he had more abrasions on his legs. Resident 35 pulled back the sheet covering his legs, and two more square dressings were intact on his right lower leg, both with the date of 8/1 written on them. Resident 35 stated the nurses had not assessed or treated his skin conditions, and he had noticed the two dressings on his legs that morning. A record review was conducted on 8/5/25. A Nursing admission Evaluation, dated 7/24/25, indicated Resident 35 had 11 areas on his skin with bruising, scabs, or wounds. Each of the 11 areas was described with color and size. Underneath the skin assessment was the following instructions: NOTE: Following the completion of the admission evaluation, a Wound Evaluation.must be opened for each wound.The Treatment Administration Record (TAR) for July and August 2025 was reviewed. Six of the skin areas had treatments (cleansing, medication and specialty bandages) discontinued on 7/29/25 without explanation. Five skin areas remained with orders for treatment. Wounds on the sacrum (bone at the base of the spine), and upper back had treatments daily, and nursing staff signed off each as completed daily. The remaining three wounds had treatment orders as follows:1. Left elbow, cleanse and apply medications, cover with gauze every other day. This treatment was signed off as completed on 8/1/25 and 8/3/25.2. Right hand, cleanse, apply medication then cover with gauze every other day. This treatment was signed off as completed on 8/1/25 and 8/3/25.3. Right leg, cleanse, dry, apply medication then cover with a dressing every other day. This treatment was signed off as completed on 8/1/25 and 8/3/25. A concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON) on 8/6/25 at 2:07 P.M. Per the ADON, a skin assessment was conducted when a resident was admitted . The ADON reviewed the Nursing admission Assessment and stated all 11 wounds should have been on the TAR. The ADON could not explain why treatment orders had been discontinued. The ADON stated the facility did not have a nurse specifically for wound care, and the nurse assigned to the resident daily had the responsibility for ensuring all treatments were completed according to the physician's order. An interview with the Director of Nursing (DON) was conducted on 8/7/25 at 11 A.M. Per the DON, nurses were responsible for providing wound treatments according to the physician's order. The DON stated the nurses should follow the physician's orders and complete the wound care, but not sign off the TAR as completed if the dressings had not been changed. The DON stated the risk to the resident was the wound could worsen, or lead to infection. Per a facility policy, revised October 2010 and titled Wound Care, .Verify that there is a physician's order for this procedure.Dress wound.Mark.with initials, time, and date and apply to dressing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1. Based on observation, interview and record review, the facility failed to assess, monitor and provide adequate supervision to prevent accidents for three of four residents (Resident 15, 21 and 60) reviewed for falls when:1. Resident 15 was not reassessed for fall risk following a fall, 2. Resident 21 was not accurately reassessed for fall risk following a fall, and,3. Resident 60 was left unsupervised in the facility dining room.This deficient practice placed residents with fall risks for potential accidents with recurrent falls, injuries and further health decline.Findings:1. Resident 15 was admitted to the facility on [DATE] with diagnoses to include unsteadiness on feet and history of falling, per a facility Face Sheet.An observation of Resident 15 was conducted on 8/4/25 at 9:45 A.M. Resident 15 was in bed and did not respond to questions asked.A record review was conducted on 8/5/25.Resident 15's Staff Assessment for Mental Status (an assessment conducted when the resident cannot respond to interview questions) score was three, indicating severely impaired, or never/rarely made decisions.Resident 15's Minimum Data Set (an assessment tool) indicated Resident 15 needed some help with walking, and used a walker or wheelchair.A Morse Fall Scale assessment (a scale used to assess fall risk based on six factors, including history of falling, diagnosis, ability to walk, aides used when walking, use of specialty medications, and mental status), conducted on admission 6/17/25, indicated Resident 15 was at, low risk for falls.A Clinical Note, dated 7/18/25, indicated Resident 15 had fallen in the hallway while returning to his room. No Morse Fall Scale assessment was identified following the fall.An interview was conducted with Certified Nursing Assistant (CNA) 11 on 8/5/25 at 2:12 P.M. CNA 11 stated she was assigned to Resident 15 often. CNA 11 stated she was not aware Resident 15 had fallen. CNA 11 stated Resident 15 got confused, so staff needed to monitor him to keep him safe.An interview was conducted with Licensed Nurse (LN) 12 on 8/5/25 at 2:20 P.M. LN 12 reviewed the instructions for using the Morse Fall Scale assessment and stated, He (Resident 15) has many diagnosis, and he had a fall before being admitted to the facility. LN 12 stated, The scale is difficult to understand. I think we need more inservicing to learn to use it right.An interview was conducted with the Director of Nursing (DON) on 8/5/25 at 2:30 P.M. The DON stated the Morse Fall Scale was conducted on admission and completed by the admissions nurse. The DON stated a new Morse assessment should be completed after a fall to reassess the risk. Per the DON, a Morse assessment was not conducted after Resident 15 fell, but it should have been completed. The DON stated if a Morse Fall assessment was wrong, or missing, We miss the opportunity to render the care necessary to prevent another fall.Per a facility policy, revised March 2018 and titled Assessing Falls and Their Causes, The purposes of this procedure are to provide guidelines for assessing a resident after a fall.Residents must be assessed upon admission and regularly afterward.Documentation:.completion of a falls risk assessment. 2. Resident 21 was admitted to the facility on [DATE] with diagnoses to include dementia (a loss of memory, thinking or language abilities) and weakness, per the facility Face Sheet.An interview was conducted with Resident 21's family member (FM 11) on 8/4/25 at 10:03 A.M. Resident 21 did not respond to question asked. FM 11 stated Resident 21 had slipped from her bed and was found on the floor recently. FM 11 was not certain whether there had been other falls at the facility. FM 11 stated since Resident 21 had fallen, she probably needed to be watched carefully since she got confused and could not communicate well with staff.A record review was conducted on 8/7/25.Resident 21's Staff Assessment for Mental Status score was 3, indicating , indicating severely impaired, or never/rarely made decisions.A Morse Fall Scale assessment, dated 5/16/25 indicated a score of 40, or Low Risk for falls.A Clinical Note, dated 6/3/25, indicated Resident 21 was found on the floor inside of her room. No environmental reasons were listed as a rationale for the fall.A Morse Fall Scale assessment, dated 6/3/25, indicated a score of 40, which according to the Morse Fall Risk Level, was low risk. Item #1 asked if the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a, History of falling; immediate or within 3 months. and the nurses response was No. Directions for the question were listed under the scoring questions. Directions for Item #1 indicate, History of Falling: This is scored as 25 if the patient has fallen during the present hospital admission.Note: if a patient falls for the first time, then his or her score immediately increases by 25.An interview was conducted on 8/7/25 at 10:16 A.M. with CNA 12. CNA 12 stated she was not aware Resident 21 had fallen. CNA 12 stated if a fall had occurred, she would have gotten a report from the CNA who worked the shifts before her. CNA 12 stated Resident 21 tried to get out of bed occasionally, and is often seen with her legs extended beyond the bed. CNA 12 stated Resident 21 was probably at risk for falls because of her confusion, but she was not aware of an incident.An interview and record review was conducted with LN 11 on 8/7/25 at 10:34 A.M. LN 11 stated he was not aware Resident 21 had had a fall. LN 11 reviewed the Morse Fall Risk scores for Resident 21 and stated, The risk level could be too low, this might cause us to not implement the right interventions to prevent additional falls.On 8/7/25 at 11:30 A.M. an interview was conducted with the DON. The DON stated following a fall, she would expect a Morse Fall Risk Level to increase. The DON stated, We may need to do some training on the use of this assessment, or consider another tool.Per a facility policy, revised March 2018 and titled Falls and Fall Risk, Managing, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling. 3. A review of Resident 60's admission Record indicated Resident 60 was re-admitted to the facility on [DATE] with diagnoses which included a history of dementia (a progressive state of decline in mental abilities).A record review of Resident 60's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/30/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of three points out of 15 possible points which indicated Resident 60 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 8/4/2025 9:52 A.M., an observation was conducted in Resident 60's room. Resident 60 was found in at the Valley View dining room of the facility unsupervised sitting on her wheelchair with a blanket that covered her legs. On 8/04/2025 10:00 A.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 60 had two most recent (July 2025) histories of falling in the facility on 7/8/25 where she fell while on the wheelchair in the Valley View dining room due to wheeling self and leaning forward then climbing down andlanding on her bottom. The ADON stated her next fall happened on 7/23/25 while Resident 60 was in her room when Licensed Nurse (LN) 25 heard a noise and found her alone in her bathroom with her right leg folded on the knee on the floor and left leg folded at the knee facing up. The active fall care plans (undated) were reviewed that indicated: .At risk for falls/ fall related injury related to history of falls, impaired mobility, impaired balance/ gait [walking], psychotropic [psych medications]/ cardiovascular [heart] meds, sensory impairment, cognitive impairment, weakness, history of fall, FTT [failure to thrive], risk for malnutrition, HTN [hypertension: high blood pressure], COPD [chronic obstructive pulmonary disease-respiratory difficulty].6/6/24:Unwitnessed fall, 8/3/24: Unwitnessed, fall, 5/13/2025: Witnessed/Assisted fall, 7/8/25: Witnessed Fall, 7/23/25 [Resident 60's name] readmitted with diagnosis of R) [right].intertrochanter femur fx [fracture- a break in the upper part of the thigh bone]. Care plan interventions indicated, .Resident to be placed in observable area for close monitoring. Redirect as needed when attempting to get up unassisted.Supervise ambulation to prevent falls or other injuries if [Resident 60's name] is unsteady.On 8/4/2025 at 11:42 A.M., and observation was conducted at the Valley View dining room. Resident 60 was in the dining room in her wheelchair wheeling self while leaning forward with a blanket covering her legs without staff supervision.On 8/6/2025 at 7:57 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 24. CNA 24 stated she was assigned to Resident 60 on 7/23/25 where she was found in the bathroom. CNA 24 stated the incident happened during the evening shift and heard Resident 60 scream from another resident's room. CNA 24 stated Resident 60 was in the dining room prior to the fall incident (7/23/25 (continued on next page)

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	555134	A. Building B. Wing	08/07/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the bathroom) and was going to assist her back to her bed for a nap but Resident 60 refused and instead Resident 60 wheeled herself back to her room while CNA 24 supervised. CNA 24 stated Resident 60 needed supervision and required assistance with transfers due to unsteadiness with mobility. CNA 24 stated Resident 60 was a high fall risk and was ambulatory prior to the right leg fracture she sustained after the fall on 7/23/25. CNA 24 stated that the Valley View dining room had staff available during mealtimes and was used by residents (any facility residents) for activities to listen to music or watch television but there was not an assigned staff assigned after mealtimes.On 8/6/2025 at 10:51 A.M., an interview was conducted with LN 25. LN 25 stated she heard a noise from Resident 60's bathroom and found Resident 60 on the floor complaining of right leg pain and was unable to move the right leg. LN 25 stated Resident 60 told her that she (Resident 60) was trying to reach the trashcan. LN 25 stated Resident 60 can get confused and must have gone to the bathroom so quickly. LN 25 stated the Valley View dining room was for residents' (any facility residents) use after mealtimes and there was no staff assigned specifically to supervise residents (any facility residents) who chose to stay in the dining room after mealtimes. LN 25 stated there should be staff present if residents (any facility residents) including Resident 60 to be supervised to prevent accidents such as falls.On 8/6/2025 at 4 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that her expectations were for staff to not leave any facility residents out at the Valley View dining room and left unattended to prevent falls or injuries from happening. The DON stated Resident 60 should not be left unsupervised because she was a high fall risk.A review of the facility's policy and procedure titled FALL assessment dated 3/2018, indicated, .The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 10.71%. Three medication errors were observed, a total of 28 opportunities during the medication administration process for one of three randomly observed residents (Residents 22, 75 and 76)As a result, the facility could not ensure medications were correctly administered to all residents.Findings:On 8/6/25 at 8:03 A.M., an observation of medication administration was conducted with Licensed Nurse (LN) 1. LN 1 prepared and administered medication to Resident 76. Eight pills or capsules were administered.A record review was conducted on 8/6/25. Resident 76 had a physician's order for the following medications:Artificial Tears 1%00.2%-0.2% eye drops, three times daily,Artificial Eye Lubricant 83%-15% ointment both eyes daily, andbudesonide 0.5 milligrams/2 milliliters suspension for nebulization inhalation (an inhaler for breathing problems) twice a [NAME] undated facility document, titled Medication Time, was reviewed. Medications ordered three times daily were to be administered at 9 A.M., 1 P.M. and 5 P.M.Medications ordered daily were to be administered at 9 A.M.Medications ordered twice a day were to administered at 9 A.M. and 5 P.M.On 8/7/25 at 9:30 A.M., an interview was conducted with LN 1. LN 1 stated she did not administer the eye drops, eye lubricant or inhaler during the medication administration. LN 1 stated it was important to administer all medications ordered by the physician at the correct time of day so the medication would be effective. On 8/7/25 at 11 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for nurses to administer all medications at the same time so the medications were given according to the physician's order, and so the resident did not have nurses coming into the room with medications multiple times. Per a facility policy, revised April 2019 and titled Administering Medications, Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure foods in a residents' personal food refrigerator (located in the resident dining room) were labeled and dated with the discard date, per facility policy.This failure had the potential for residents to experience food borne illness. Findings:An observation and interview was conducted with Licensed Nurse 1 (LN 1) on 8/4/25 at 12:02 P.M., of the residents' personal food refrigerator located in a resident dining room. The refrigerator contained a large clear plastic zip-lock baggie, with two cupcakes inside. One cupcake was green with white frosting and the other cupcake was yellow with white frosting. The clear plastic bag had no label to indicate which resident the cupcakes belonged to, or the date the cupcakes were placed in the refrigerator. LN 1 stated, the food should be labeled and dated, because no one knows who it belongs to or how long it has been in the refrigerator. LN 1 stated the cupcakes might be old and someone could get sick if the food was not discarded within three days. An interview was conducted with the Dietary Staff Supervisor (DSS) on 8/4/25 at 12:10 P.M. The DSS stated licensed nurses were responsible for checking the resident food refrigerated daily to ensure all foods were labeled and dated. The DSS stated she expected all food to be labeled with the resident's name and include the date it was placed in the refrigerator. The DSS stated all food placed in the refrigerator needed to be discarded after 72 hours. The DSS stated she expected staff to remove any food that was not dated or labeled, to prevent residents from getting sick. An interview was conducted with the Registered Dietitian (RD) on 8/6/25 at 12:05 P.M. The RD stated she expected all food inside the resident refrigerator to be labeled and dated. The RD stated if not labeled and dated, residents could get sick, because no one knows who the food belonged to or how long it had been inside the refrigerator.An interview was conducted with the Director of Nursing (DON) on 8/7/25 at 10:49 A.M. The DON stated she expected the licensed nurses to inspect the resident refrigerator every day and to remove food not labeled and dated, to prevent food borne illness. According to the facility' policy, titled Foods Brought by Family/Visitors, dated July 2017, .7.Food brought in by family/visitor.b. Perishable foods must be stored in re-sealable containers.in a refrigerator. Containers will be labeled with the resident's name, room number, the item and the use by date. No more than 3 days for perishable foods.

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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 observation, interview, and record review, the facility failed to follow infection control practices for one of eight residents (Resident 58) reviewed by not promptly removing a used meal tray that was left within reach of other residents in the dining room.This deficient practice placed all residents using the dining room at risk for exposure to germs that could cause illness, choking hazards, and potential allergic reactions from consuming food that was not theirs.Findings: On 8/4/2025 at 12:02 P.M., an observation for dining was conducted in the Valley View dining room. Resident 58 was observed sitting on a wheelchair wheeling self towards the hydration cart and grabbed a waffle from a used meal tray that was stored below the hydration cart and ate it.On 8/4/2025 at 12:10 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1, in the Valley View dining room. CNA 1 stated that they (nursing staff) should be checking the dining room and putting away used meal trays that are outside of the dining room. CNA 1 stated residents in the Valley View nursing station (such as Resident 58) have memory problems and could be at risk for food-related illness, allergic reactions, and choking hazards if consuming foods that do not belong to them.On 8/6/2025 at 8:54 A.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated Resident 58 has a history of dementia (a progressive state of decline in mental abilities) and stated the used meal tray should not have been stored in the hydration cart because the hydration cart was considered clean and used by other residents who wanted a drink while in the dining room. The ADON stated the used meal trays were considered dirty and should be removed promptly after a meal is consumed in the dining room and placed in the used meal tray carts outside of the dining room for infection prevention. The ADON stated Resident 58 could have gotten a food-borne illness, an allergic reaction or choke because she checked the tray and it was not Resident 58's meal tray.On 8/6/2025 at 3:41 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was for the used trays to be removed promptly and placed in the dirty tray carts. The DON stated that this was an infection control issue because of germs that could be exposed from dirty meal trays. The DON further stated that Resident 58 could have been exposed to germs, choked or had a food allergy from consuming somebody else's food. The facility did not provide a policy and procedure for infection control with dining.