STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555749	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village Care Center	2125 North Olive Avenue Turlock, CA 95382

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to be informed and make decisions about their care for one of four sample residents (Resident 1) when the facility did not obtain informed consent prior to increasing Resident 1's Seroquel (an antipsychotic medication that balances certain chemicals in the brain to help the person feel calmer and think clearly) dosage.This failure had the potential to result in Resident 1 receiving psychotropic medication (medication that affects brain activities associated with mental processes and behavior) without proper understanding or consent, compromising their right to participate in medical decision-making.Findings:During a review of Resident 1's admission Record (a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including blindness, hypothyroidism (condition where a person's thyroid [small gland in neck] didn't make enough hormones), arthritis (condition that caused pain, swelling and stiffness in joints, depression, visual hallucinations (when a person saw things that weren't really there) and, anxiety.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had no cognitive impairment.During a review of Resident 1's Medication Administration Record (MAR), it was noted Resident 1 had a dose increase of Seroquel. The previous order, in effect from 1/31/25 to 3/1/25, was for Seroquel 25 mg daily at 9:00 a.m. for psychotic features manifested by episodes of hallucinations, and 50 mg at 9:00 p.m. for the same indication. The current order started on 3/1/25-current reflected a change to 50 mg at 9:00a.m. and 9:00 p.m. for depression with psychotic features manifested by hallucinations.During a concurrent observation and interview on 6/25/25 at 12:04 p.m. with Resident 1 and her Responsible Party (RP) 5, Resident 1 was observed eating lunch with her husband and daughter. Resident 1 stated she enjoyed the meal and responded to questions appropriately. RP 5 stated Resident 1 had an appointment with her private psychiatrist from Sutter every two months via virtual meeting. She reported that the Social Services Director (SSD) arranged the virtual meetings, which she joined virtually. During a review of document titled Clinical Notes, dated 4/22/25, the Clinical Notes indicated Resident 1's psychiatrist recommended Resident 1's Seroquel dose be increased to 50 mg in the morning.During a concurrent interview and review of Resident 1's electronic health record on 6/26/25 at 12:09 p.m. with the Director of Nursing (DON), the DON stated the last informed consent for Seroquel was obtained on January 31, 2025. The DON stated there was no informed consent documented for the subsequent Seroquel dose increase to 50 mg twice daily. The DON stated it was important to ensure Resident 1 was aware that the medication dose was being increased and informed of the potential side effects associated with the medication.During an interview on 6/26/25 at 3:40 p.m. with the Registered Pharmacist (RPh), the RPh stated informed consent was required before increasing a medication dose. The RPh explained it was important for the residents to be aware of the potential adverse effects, understand the reason for the increase in the dose and have the opportunity to agree or disagree with the change.During a review of the facilities policy and procedure (P&P) titled, Psychotropic Medication Use, revised February 2025, the P&P indicated 3. Psychotropic medication management is an interdisciplinary process that involves the resident, family and or representative .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that four of four sampled residents (Resident 299, Resident 35, Resident 1, and Resident 18) were free from unnecessary psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications when:1. For Resident 299, Seroquel (an antipsychotic medication that balances certain chemicals in the brain to help the person feel calmer and think clearly), was initiated without an appropriate indication, the facility did not document, implement, or monitor resident specific non-pharmacological interventions (ways to help someone feel better or manage a health problem without using medicine) prior to the initiation and continued used of Seroquel, include objective measurable behavioral goals with timeframes on the care plan for adequate behavioral monitoring, , and adequately monitor, track and document behavioral episodes, and side effect monitoring. These failures placed Resident 299 at risk for unnecessary medication use, adverse side effects and a decline in psychosocial well-being.2. For Resident 35, the facility did not implement or monitor individualized non-pharmacological interventions, and did not adequately monitor, track, document behavioral episodes and side effects related to Resident 35's use of divalproex (a psychotropic medication used to help control mood and behavior), Lexapro (a psychotropic medication used to balance chemicals in the brain to improve mood and help them feel calmer), Rexulti (an antipsychotic medication used to calm the brain, making it easier for the person to feel more balanced and act normally), and lorazepam (a psychotropic medication used to slow down activity in brain so a person could relax and feel more in control).These failures placed Resident 35 at risk for prolonged and potentially unnecessary use of psychotropic medications without appropriate monitoring or oversight.3. For Resident 1, the facility did not implement or monitor individualized non-pharmacological interventions, and did not adequately monitor, track and document behavioral episodes for the use of Seroquel, Zoloft (a psychotropic medication used to balance chemicals in the brain to improve mood and help them feel calmer), and lorazepam. These failures placed Resident 1 at risk for inappropriate treatment decisions, continued use of psychotropic medication without adequate clinical oversight and potential adverse effects.4. For Resident 18, the facility did not implement or monitor individualized non-pharmacological interventions and did not adequately monitor, track and document behavioral episodes related to buspirone (medication that calmed certain parts of the brain, so the person didn't feel worried all the time), Lexapro, and Seroquel use.These failures place Resident 18 at risk for continued use of psychotropic medication without appropriate clinical justification or oversight.1. During a review of Resident 299's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission Record indicated, Resident 299 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), unsteadiness on feet, muscle weakness, anxiety, falling and hyperlipidemia (high amounts of fat in the blood).During a review of Resident 299's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 3 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 299 had severe cognitive impairment.During a review of Resident 299's Hospital Progress Note, dated 6/11/25, the Hospital Progress Note indicated, .on the afternoon of 6/11/25 [Resident 299] became extremely agitated and combative, refused to take oral medications and removed her intravenous (IV) line . Although Seroquel 25 mg (milligram, a unit of measurement) daily was ordered, it was not administered to Resident 299.During a review of the facility's Physician Order Sheet, dated 6/27/25, the Physician Order Sheet indicated, active order for Quetiapine [Seroquel] 25mg, one tablet every 8 hours as needed for agitation, for fourteen days, starting on 6/16/25.During an observation on 6/25/25 at 11:57 a.m., Resident 299 was observed in her room, sitting in a chair and chatting with her husband. Resident 299 appeared pleasant and greeted the observer by saying hello.During an interview on 6/25/25 at 3:55 p.m. with the Infection Preventionist (IP), the IP stated her interactions with Resident 299 had been limited, due Resident 299 being newly admitted on [DATE]. However, the IP stated Resident 299 appeared pleasant and cooperative with care and was not currently exhibiting any complaints. The IP stated behaviors were monitored through Resident 299's Treatment Administration Record (TAR) and the documentation of behaviors and potential medication side effects would typically be completed at the end of each shift. The IP

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person centered Care Plan (a document that outlines a personalized approach to an individual's healthcare and support needs) for two of two sampled (Residents 6 and 20) when:1. Resident 20 had no Care Plan created for the use of their mobility rails (rails on the side of the bed which help a resident turn and move in bed)This failure had the potential to cause Resident 20's use of mobility rails to not receive proper monitoring or support to ensure they were used safely.2. Resident 6 did not have a care plan developed for ordered padded side rails.This failure had the potential to result in harm to Resident 6 if the padded side rails were removed.Findings: 1. During an observation on 6/23/25 at 3:31 p.m. in Resident 20's room, Resident 20 had mobility rails raised on the left and right side of his bed. During a review of Resident 20's Face Sheet (FS- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/25/25, the FS indicated, Resident 20 was admitted to the facility with a diagnosis of spastic hemiplegia of the right side (a condition where the muscles on one side of the body are stiff and experience involuntary contractions, leading to weakness and difficulty with movement) and muscle weakness (a reduced ability to generate force in one or more muscles) During a concurrent interview and record review on 6/24/25 at 3:44 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 20's Care Plan dated 6/24/25 was reviewed. LVN 1 stated Resident 20 did not have a care plan created for his use of mobility rails. LVN 1 stated Resident 20's use of mobility rails should have had their own fully developed Care Plan. LVN 1 stated mobility rails are an assistive device, and care planning was necessary in order to monitor and ensure their safe usage. During a concurrent interview and record review on 6/26/25 at 3:16 p.m. with the Minimum Data Set Nurse (MDSN), Resident 20's Care Plan dated 6/26/25 was reviewed. The MDSN stated Resident 20 did not have a specific Care Plan created for his use of mobility rails. The MDSN stated an appropriate and complete person centered care plan was important in order to properly monitor Resident 20's use of assistive equipment and ensure their safety. During an interview on 6/26/25 at 9:38 a.m. with the Director of Nursing (DON), the DON stated Resident 20's Care Plan needed to be specific, and person centered. The DON stated Resident 20 had the use of his rails listed as an intervention for another care plan, but it needed to be its own specific care plan in order to better monitor his use of the assistive device. During a review of the facility's MDS Nurse, Job Description, dated 6/2/25, the Job Description indicated . The MDS Nurse . is ultimately responsible for the oversight and coordination of the federally mandated resident assessment instrument (RAI) process, which includes the MDS assessment, care area assessment, and care plan development and revision . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/22, indicated, . 7. The comprehensive person-centered care plan: a. includes measurable objective and timeframes. b. describes the service that are to be furnished to attain or maintain the resident's highest practicable physical mental and psychosocial well-being including: (1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights including the right to refuse treatment . c. includes the residents stated goals upon admission and desired outcomes; d. build on the resident's strengths; and e. reflects currently recognized standard of practice for problem areas and conditions . 2. During an observation on 6/23/25 at 3:38 p.m. in Resident 6's room, observed Resident 6 awake in bed with head of bed raised. Observed padded upper left and upper right side rails. During an observation on 6/24/25 at 9:15 a.m. in Resident 6's room, observed Resident 6 awake in bed and covered with a blanket. Observed padded upper left and upper right side rails. During a concurrent observation and interview on 6/26/25 at 8:29 a.m. with Certified Nursing Assistant (CNA) 2 in Resident 6's room, Resident 6 observed in bed awake, with head of bed raised and both left, and right upper side rails padded. CNA 2 stated Resident 6's upper right and left side rails are padded so the resident does not hit herself when she moves around. During a review of Resident 6's Face Sheet dated 6/26/25, the Face Sheet indicated Resident 6 was admitted into the facility on 2/27/17. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) Section C - Cognitive Patterns dated 6/5/25, the MDS Section C - Cognitive Patterns indicated Resident 6's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 3 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, 13-15 cognitively intact) which indicated Resident 6 had a severe cognitive impairment. During a review of Resident 6's MDS Section I- Active Diagnosis dated 6/5/25, MDS Section I- Active Diagnosis indicated in the neurological section, Resident 6 had an active diagnosis of seizure disorder (sudden, temporary disruption in brain activity that causes involuntary changes in behavior, movement, sensation or consciousness) or epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures). During a review of Resident 6's June 2025 Physician Order Set dated 6/26/25, the June 2025 Physician Order Set indicated Resident 6 had seizure precautions in place with notes, . monitor for seizures [related to] levetiracetam [antiseizure medication], padded rail . The June 2025 Physician Order Set indicated this was ordered on 2/4/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/25 at 1:57 p.m. with LVN 1, Resident 6's Care Plan Report (undated), was reviewed. The Care Plan Report indicated Problem: [Resident 6] is at risk for injuries related to seizure activity. Status: Active (Current). Goals: [Resident 6] will be free from seizure activity through the next 90 days. Status: Active (Current) Goal Date: 9/29/2025. Interventions: Administer medications per physician orders-monitor side effects and adverse reactions associated with medication use-observe for any signs/symptoms indicated in black box warnings--- Status: Active (Current) . LVN 1 stated unable to locate padded side rails in the care plan and stated it should be included in the care plan. LVN 1 stated it is important to include padded side rails for Resident 6 because it is a person-centered care plan and if this is not included the nurse or staff will not know Resident 6 would require this intervention. LVN 1 stated the padded side rails are there so the resident does not hurt herself. During an interview on 6/27/25 at 9:01 a.m. with the DON, the DON stated the expectation is for Resident 6 to have padded side rails included in the care plan. The DON stated it is important to have padded side rails included in the care plan for staff to know what the resident requires for care. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated, .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure care and services were provided in accordance with professional standards of quality for three of five sampled residents (Resident 8, Resident 5 and Resident 12) when:1.For Resident 8, there was no documented evidence of the removal of the previously applied medication patches from the residents' back.This failure to track and document patch removal had the potential to result in overmedication and adverse effects.2. Social Service Director (SSD) did not have a system in place to monitor Resident 8 for a follow up dental appointment.This failure had the potential to result in Resident 8's dental care to not be completed.3.Resident 5 did not have a running total of daily fluid intake calculated and documented.This failure had the potential to prevent a clear assessment of hydration status and overall fluid balance.4. Resident 12's potassium lab result was not communicated to the prescriber, and there was no evidence of clinical follow-up or intervention.This failure had the potential to place the resident at risk for complications related to abnormal potassium levels.Findings:1. During a review of Resident 8's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission Record indicated, Resident 8 was admitted to the facility on [DATE] with a diagnoses including hypertension (HTN-high blood pressure), and pain in both left and right shoulders. During an observation on 6/24/25 at 9:09 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed applying a lidocaine 4% (topical medication used to treat pain) patch to Resident 8's right shoulder. LVN 1 did not date, time or initial the medication patch at the time of administration. During a concurrent interview and record review of Resident 8's chart on 6/24/25 at 12:02 p.m. with LVN 1, LVN 1 stated she did not know when the lidocaine 4% patch applied on 6/23/25 was removed. The Medication Administration Record (MAR) indicated a patch was applied on 6/23/25 at 9:00 a.m.; however, there was no documentation of its removal. LVN 1 stated lidocaine 4% patches had a 12-hour duration to be applied on the skin and stated she had never dated or initialed patches upon application. LVN 1 stated there was no clear way to determine when the patch was removed since the patches were not time and date marked. During a review of the Medication Guide Instructions for lidocaine 4% patch last revised February 2025, the instructions indicated, the patch may be left on the skin for up to 8 or 12 hours .do not leave any patch on for longer than the stated time period .During an interview on 6/24/25 at 3:04 p.m. with the Director of Nursing (DON), the DON stated that staff should have an order to remove the medication patch. The DON stated the expectation is for nurses to have a time, date and initial of when medication patches are applied. The DON stated the nurse applying the patch is also expected to generate a corresponding removal order in the MAR to ensure patches are not left on the skin for an extended period, as this could increase the risk of skin irritation. During a review of the Specialist Pharmacy Service (SPS) article, Using Transdermal Patches Safely in Healthcare Settings, published 5/3/22, the article indicated, Healthcare staff should use a consistent method for recording patch application and removal, including date and time and site rotation, to mitigate medication errors and skin. 2. During a concurrent observation and interview on 6/23/25 at 3:36 p.m. with Resident 8 in room, Resident 8 observed to be awake, well groomed and in wheelchair. Observed Resident 8 to be missing two upper front teeth. Resident 8 stated had partial upper denture (removable dental appliance designed to replace multiple missing teeth while some nature teeth remain) prior to admission but no longer had them. Resident 8 stated the dentist did a mold for new partial upper dentures but that was months ago and had not heard anything since. Resident 8 stated not having upper partial dentures had not affected eating but was annoying to not have teeth. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Face Sheet dated 6/27/25, the Face Sheet indicated Resident 8 was admitted into the facility on 4/4/2024. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool) Section C - Cognitive Patterns dated 3/7/25, the MDS Section C - Cognitive Patterns indicated Resident 6 ' s Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 10 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, 13-15 cognitively intact) which indicated Resident 8 had a moderate cognitive impairment. During a concurrent interview and record review on 6/25/25 at 1:35 p.m. with SSD, Resident 8's dental note dated 2/12/25 was reviewed. The dental note indicated, .Prosthetic [device designed to replace a missing part of the body] Evaluation: NOA [notice of authorization], PUD [partial upper denture]/FUD [full upper denture] (F/U [follow up] on framework) . SSD stated it appeared the note stated the dentist would follow up with Resident 8 but stated she was not familiar with the verbiage used by the dentist. SSD stated she should know how to read the dental notes since she is the one responsible for coordinating resident care. SSD stated she was not informed Resident 8 required a follow-up. SSD stated, when informed by the dentist a follow up is needed for a resident it would be her responsibility to do a follow-up but stated she does not maintain a list of residents who require a follow-up visit. SSD stated she had not kept track of what needs to be done for residents and what residents had been seen. SSD stated a note will not be written when documents are uploaded but will only upload the document completed by the dentist. During an interview on 6/27/25 at 9:38 a.m. with the Director of Nursing (DON), the DON stated SSD should be putting in notes for all updates regarding residents medical care in their chart. The DON stated SSD ensures follow-ups are done but they are not written down. The DON stated SSD needs to document any referrals, consults and follow-ups because if this is not done, there is no proof they occurred. The DON stated it is best practice to document anything about patient care because there needs to be some record that staff and the facility did something. During a review of the job description Director of Social Services dated 10/1/24, the Director of Social Services indicated, . Position Summary .This position is responsible for directing the social service functions which include the planning, development and implementation of appropriate programs designed to address the emotional and psychological needs of campus residents in multiple levels of care and their families. This position is responsible for actively participating in the resident assessment process . This position serves as a resident advocate within the campus . The Director of Social Services indicated, .Major Responsibilities . Provide regular contacts with families and act as a liaison for families with the resident care team . Maintain current documentation in resident ' s health record as it related to the social services care component of the comprehensive care plan for each resident as identified by the interdisciplinary team. Assure that appropriate care plan documentation as required by regulations and need is complete . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 5's admission Record, the admission Record indicated, Resident 5 was admitted to the facility on [DATE] with a diagnoses including dysphagia (difficulty swallowing), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a concurrent observation and interview on 6/24/25 at 7:59 p.m., during the medication administration task, LVN 2 poured 30 ml of water into Resident 5's gastrostomy tube (g-tube -a small tube that goes directly through the skin into the stomach, and is used to give food, water or medicine to someone who can't eat normally), administered three medications and flushed 30 ml of water between each medication. Following the medication administration, LVN 2 administered Resident 5's bolus (a set amount of liquid) tube feeding of 240 ml of Jevity (brand of liquid nutrition) and completed the feeding with a final 30 ml water flush. During an interview on 6/24/25 at 2:23 p.m. with LVN 2, LVN 2 stated Resident 5 received 240 ml per g-tube feeding. LVN stated the total daily fluid intake was not being calculated. LVN 2 stated there was no formal policy on flushing, but leadership had instructed staff to administer 30ml of water with each medication. LVN 2 acknowledged this practice could contribute to fluid overload (when the body had too much water or other fluids in it) in Resident 5, who had a diagnosis of CHF. LVN 2 stated Resident 5 did not have any monitoring in place for edema (swelling) and did not have an order for diuretic (medicine that helped the body get rid of extra water) medication. During a concurrent interview and review of Resident 5's electronic health record, Resident 5's fluid orders were reviewed. Registered Nurse (RN)1 stated Resident 5 received her g-tube feedings six times per day, which totaled 1,440 ml of fluid daily. RN 1 stated the current order indicated 240 ml every 4 hours. During an interview on 6/24/25 at 3:27 p.m. with the DON, DON stated that nurses were expected to calculate the total volume of enteral feedings, including free water, and document it directly in the resident's chart. The DON stated input and output are tracked, and all fluid intake is calculated based on the MD's order. The DON stated that while there was an order for enteral flushes, there was no specific order for the total volume of enteral feed and free fluid. The DON stated there should be an order for the total daily volume of enteral feed and free fluid to ensure Resident 5 is receiving the correct amount of fluid. The DON stated that because Resident 5 has CHF, receiving too much fluid could result in fluid overload, while not receiving enough could lead to dehydration. The DON added the MD typically provided an order for the total volume to be administered each day. During a concurrent interview and review of Resident 5's electronic health record on 6/25/25 at 1:42 p.m. with the Registered Dietitian (RD), the RD stated she was responsible for making recommendations for the resident's total daily fluid intake. The RD explained that free water came from the formula itself, as well from flushes administered before and after feedings and between medications. The RD stated Resident 5 was NPO (nothing by mouth). The RD stated the last full nutritional assessment was completed on 4/30/25 by the consultant dietitian while she was on leave The consultant RD's 4/30/25 assessment was based on Resident 5's weight of 46 kg and recommended a total fluid intake of 1,610 ml per day. At that time Resident 5 received Jevity 1.2 at 60ml/hour as a continuous feeding, along with 160 ml of free water every 8 hours. The calculated free water from the Jevity 1.2 at 60ml/hr was 1,162 ml, plus an additional 480 ml from flushes, totaling 1,642. On 5/15/25, the feeding order was changed from continuous to bolus. The current regimen included Jevity 1.2 at 240ml every four hours, providing approximately 1,162 ml of free water daily. The RD stated additionally, Resident 5 received 30 ml flushes totaling 360 ml and 30 ml flushes before and after each medication administration (total approximately 360ml), bringing the estimated total daily fluid intake to approximately 1, 882 ml. During a continued interview on 6/25/25 at 2:19 p.m. with the RD, the RD stated the amount of medication Resident 5 receives can impact overall flid intake. The RD stated there should be a goal for Resident 5's estimated fluid needs to ensure she is receiving an adequate amount without exceeding her requirements. The RD stated signs of fluid overload, such as edema, could indicate excessive fluid intake. The RD stated she was aware of Resident 5's diagnosis of CHF which further emphasized the importance of carefully managing total fluid volume. During an interview on 6/25/25 at 2:52 p.m. with the RD, the RD stated her goal for total daily fluid intake would have been 1,645 ml based on Resident 5's weight of 104 pounds at the time the Jevity order was changed to bolus feedings on 5/15/25. The RD stated Resident 5's actual calculated fluid intake was 1,882 ml per day, which exceeded the fluid goal. The RD stated the fluid goal would be adjusted if the resident exhibited signs of CHF such as fluid overload. The RD stated Resident 5's

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village Care Center	2125 North Olive Avenue Turlock, CA 95382

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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 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 interview and record review, the facility failed to ensure proper pharmaceutical services were provided to meet the needs of residents when the facility did not have an effective system in place to periodically reconcile all controlled substances in the facility.This failure had the potential for diversion, mismanagement, or unaccounted medication, and the potential not to meet the needs of the residents in the facility. Findings:During an interview on [DATE] at 3:13 p.m. with the Director of Nursing (DON), the DON stated that residents were typically discharged with their medications. DON stated that if a resident was deceased or a medication was discontinued, nursing staff would inform her, and the medications would be stored in a locked box in her office until destruction by both her and the consultant pharmacist. The DON stated she and the nurse would sign the disposition log and date it at the time the medication was handed to her for destruction. The DON stated she does not periodically reconcile medications in the facility and did not have a system in place. The DON stated it would be important to have a system such as that in place to ensure that no drugs go missing in the building. During an interview on [DATE] at 3:00 p.m. with the Registered Pharmacist (RPh), the RPh acknowledged the facility did not have a process in place to periodically reconcile all controlled substances in the facility and stated it was important to periodically reconcile controlled substances in order to ensure all medications were properly accounted for.During a review of the facility's Policy and Procedure (P&P) titled, Controlled Substances, revised [DATE], the P&P indicated, policies and procedures for monitoring controlled medications to prevent loss, diversion or accidental exposure are periodically reviewed and updated by the director of nursing services and the consultant pharmacist .During a review of the facility's Policy and Procedure (P&P) titled, Dispensing and Reconciling Controlled Substances, revised [DATE], the P&P indicated, controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up .

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 when the facility's medication error rate was 8 percent. There were 25 opportunities for errors and two medication errors occurred for two of four sampled residents (Resident 28, and Resident 12) when:1. Resident 28's diclofenac 1% gel (topical pain medication) dose was not correctly measured.2. Resident 12's Refresh Classic 1.4-0.6% eye drops (medication used to treat dry eye disease) were administered incorrectly in both dosage amount and technique. The quantity exceeded the prescribed amount in the left eye and the drops were placed directly in the center of the eye.These failures to follow proper medication administration practices had the potential to result in reduced effectiveness of treatment or harm to Residents 28 and 12.Findings:1. During a concurrent observation and interview on 6/24/25 at 8:34 a. m. with Licensed Vocational Nurse (LVN) 2, during a medication administration task, LVN 2 was observed filling a medication cup with diclofenac 1% to the second dram (a unit of measurement) line. LVN 2 stated the medication cup did not have gram measurements labeled on it, so she estimated the amount to be administered. The physician order was to apply 2 grams of the topical gel to Resident 28's left knee. LVN 2 was unaware that a measuring stick was included inside the medication box for accurately measuring the prescribed dosage. Additionally, LVN 2 stated she was unsure what a dram represented as a unit of measure.During a review of Resident 28's Physician Order Sheet, dated 6/25/25, the Physician Order Sheet indicated, Resident 28 had an active order for diclofenac 1% topical gel, with instructions to apply 2 grams to the left knee twice a day.During a review of the Medication Guide Instructions for diclofenac 1%, last revised May 2024, the instructions indicated, to measure the right dose, use the dosing card provided with the medication. Place a dosing card on a flat surface so that you can read the print on the card. Squeeze an even line of the medication from the tube onto the dosing card, using the marks on the card to measure the prescribed dose.During an interview on 6/24/25 at 3:04 p.m. with LVN 2, she stated it was important to ensure accuracy and to follow the physician's orders. LVN stated that staff need to match the doctor's orders and refer to the package inserts when administering medications.During an interview on 6/24/25 at 3:13 p.m. with the Director of Nursing (DON), the DON stated that a ruler should be used to measure the dose in accordance with the physician's order. The DON stated it was not the standard of practice to squeeze the medication gel into a medicine cup, as this method does not align with the prescribed dosage. The DON stated that the incorrect dosing could result in Resident 28 not receiving adequate pain control or, if too much is given, could potentially cause bruising and bleeding.During an interview on 6/26/25 at 3:00 p.m. with the Registered Pharmacist (RPh), the RPh stated the expectation when following prescriber's orders is to do so completely and accurately. The RPh stated this was important because the medication is intended to treat pain in the specific location where it is applied.2. During a concurrent observation and interview on 6/24/25 at 9:22 a.m. with LVN 1, during medication administration task, LVN 1 was observed assisting Resident 12 in opening her eyes and administering Refresh Classic 1.4-0.6% eye drops. LVN 1 placed one drop in Resident 12's right eye and two drops in the left eye, aiming for the center of each eye. LVN 1 realized she had administered an extra drop in the left eye and stated she would contact the physician. LVN 1 stated the medication is intended to moisturize the eye, and therefore, it does not matter where the drops are placed. During a review of Resident 12's Physician Order Sheet, dated 6/25/25, the Physician Order Sheet indicated, Resident 12 had an active order for Refresh Classic 1.4-0.6% eye drops to be administered as one drop in each eye three times per day.During a review of the Medication Guide Instructions for diclofenac 1%, last revised September 2024, the instructions indicated, tilt your head back, look up and pull down the lower eye lid to make a pouch.During an interview on 6/24/25 at 2:14 p.m. with LVN 1, LVN 1 stated she looked up the information and learned that it is most effective to administer the eye drop into the conjunctival sac (small pocket between the inside of the lower eyelid and surface of the eye). LVN 1 stated she informed the physician of the incorrect dose of eye drops administered to Resident 12's left eye, and Resident 12 was placed on alert charting to monitor for any potential side effects.During an interview on 6/24/25 at 3:27 p.m. with the DON, the DON stated eye drops should not be placed directly in the center of the eye, as this could potentially damage the eye or result in loss of the medication. The DON stated it was not her expectation of staff to administer drops in this manner. The DON stated eye drops are to be placed in the conjunctival sac of the eye.During an interview on 6/26/25 at 3:00 p.m. with the RPh, the RPh stated the expectation for

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with the facility policy and procedures when:1. One bottle of Resident 17's latanoprost (medication used to decrease blood pressure in the eye) was stored in the Station 1 (Whispering [NAME]) medication cart did not have resident-specific label.This had the potential to result in medication administration errors, including administration to the wrong resident, which may adversely affect resident safety.2. Discontinued medications for Resident 17, Resident 28 and Resident 32 were stored in in the active medication section of the Station 1 medication cart.This had the potential to result in the administration of discontinued medications, placing residents at risk for receiving unnecessary or inappropriate treatment.3. A bottle of house stock medication (over the counter medication available for administration to any resident in the facility) in the Station 1 medication room was expired as of 5/2025 and was not removed from active stock.This failure had the potential to result in administration of expired medication, which could affect the safety and effectiveness of treatment provided to residents.4. A partially used multi-dose tuberculin vial (a sterile liquid used in a skin test to diagnose tuberculosis [TB- serious bacterial infection of the lungs] infection) in the medication refrigerator of station 1 was opened but did not have an open date or an expiration date.This failure had the potential to result in the use of compromised or ineffective medication, which could lead to inaccurate tuberculosis skin test results and negatively impact resident and staff safety.5. An opened and partially used bottle of sterile normal saline for irrigation (saltwater solution used to clean wounds or body parts. It's made in a way to make sure it had no germs in it), labeled for single use only, was stored in the active medication section of the treatment cart of Station 2 (Heartland Place).This failure had the potential to result in contamination and posed a risk to resident health and safety. 6. Two bottles of nystatin powder (medication used to treat certain skin infections caused by fungi) were found in the treatment cart of Station 2 without resident-specific labels.This had the potential to result in medication administration errors, including administration to the wrong resident, which may adversely affect resident safety.Findings:1. During a concurrent observation and interview on 6/23/25 at 1:56 p.m. with Licensed Vocational Nurse (LVN) 3, the medication cart for Station 1 was inspected. Resident 17's latanoprost 0.005%) was stored inside a medication box without a resident identifier label on the bottle. LVN 3 acknowledged Resident 17's latanoprost bottle did not have resident-specific identifier and stated the medication bottle should be labeled because the box could be lost, and without the label on the bottle, staff would not know to whom the medication belong.During an interview on 6/24/25 at 3:27 p.m. with the Director of Nursing (DON), the DON stated the expectation of staff was the medication bottles should be labeled with a patient identifier because medications are intended for use only by the specific resident for whom they are prescribed.During an interview on 6/26/25 at 3:00 p.m. with Registered Pharmacist (RPh), the RPh stated the policy required a smaller label to be applied directly to the medication container itself, not just on the medication box as this is to prevent accidental administration.2. During an observation 6/23/25 at 2:10 p.m., the medication cart for Station 1 was inspected. For Resident 17, Rocklatan 0.02%-0.005% (medication used to decrease blood pressure in the eye) were observed stored in the medication cart. For Resident 28, and Resident 32, Zofran ODT (an oral disintegrating tablet medication used to treat nausea) 4 milligrams (mg-unit of measure) tablets were individually packaged and stored in separate clear bags and labeled with each resident's identifier.During a concurrent interview and record review on 6/23/25 at 2:35 p.m. with LVN 3, Residents 17, 28 and 32's physician orders were reviewed.A review of Resident 17's Medication Administration Record (MAR), dated June 2025, indicated the Rocklatan 0.002%-0.005% eye drops had been discontinued since 6/13/25. LVN 3 stated discontinued medications should be removed from the medication cart and added, You don't want to give discontinued medications.During a review of Resident 17's June 2025 Physician Order Sheet, dated 6/25/25, the orders indicated Resident 17's Rocklatan 0.02%-0.005% eye drops were ordered 1/17/2020 and discontinued on 6/13/25.During a review of Resident 28's Treatment/Order Update/Change in Condition, dated 3/6/25, the order indicated Resident 28's Zofran ODT 4mg every 8 hours as needed was to begin on 3/7/25 and end on 3/11/25.During a review of Resident 32's Physician Medication Orders, dated 3/12/25, the order indicated Resident 32's Zofran ODT 4mg every 8 hours as needed was to being on 3/12/25 and end on 3/19/25.LVN 3 acknowledged the medication orders reviewed for Residents 17, 28 and 32 were discontinued. LVN 3 stated the medications should have been

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to ensure proper sanitation of equipment when two of two ice machines for resident use had brown and yellow discoloration in the machines. This failure had the potential to contaminate the ice distributed to residents and the potential for residents to become ill.Findings: During a concurrent observation and interview on 6/23/25 at 2:34 p.m. with Director of Facilities Management (DFM) in the kitchen at the ice machine, DFM removed the front panel of the ice machine and observed brown and yellow staining around the perimeter of the inside of the ice machine. Surveyor conducted a tissue swipe of the areas with brown and yellow staining and brown debris was observed on tissue. Confirmed the brown debris seen on tissue with DFM. DFM stated the debris should not be there. DFM stated the ice machine is deep cleaned once a month. During a concurrent observation and interview on 6/24/25 at 9:50 a.m. with DFM at nurses' station one utility room, the ice machine was inspected. DFM removed front panel of the ice machine and brown staining was noted around the perimeter of the inside of the machine. [NAME] staining observed in water drop off area. Surveyor conducted tissue swipe of brown areas and brown debris was observed on tissue. Confirmed brown debris on tissue with DFM. DFM stated the expectation is to have all parts of the inside of the ice machine cleaned. During a concurrent observation and interview on 6/24/25 at 9:59 a.m. with Maintenance Technician (MT) in the nurses' station one utility room, MT confirmed the brown staining observed inside ice machine. MT stated both ice machines have not been cleaned in the month of June and are due to be cleaned. During an interview on 6/24/25 at 10:02 a.m. with DFM, DFM stated both ice machines are cleaned monthly but there is not a set date when they need to be cleaned. DFM stated both ice machines just need to be cleaned within the month. During an interview on 6/24/25 at 10:08 a.m. with Certified Nursing Assistance (CNA) 1, CNA 1 stated the ice from the ice machine in nurses' station one utility room is used for residents. CNA 1 stated the ice is used to keep items cold and ice placed in residents' drinks. During a concurrent interview and record review on 6/25/25 at 3:44 p.m. with Assistant Director, Facilities Management Assistant Director (FMAD) Maintenance Work Order #130824 dated 5/5/25 was reviewed. The Maintenance Work Order #130824 indicated the assignment to clean the ice machines in May was assigned on 5/5/25 and the MT completed the job of cleaning both ice machines on 5/9/25. FMAD confirmed the last time both ice machines were cleaned was on 5/9/25. FMAD stated once the MT has cleaned the ice machines, FMAD will come in and inspect the machine and ensure they are cleaned and there is no residue. FMAD stated the machines can be up and running before he comes in to inspect the machines. FMAD stated the work order for the ice machines to be cleaned is generated the first of the month and they will need to be cleaned within the month. FMAD stated it is important for the ice machines to be clean because they are used for residents and residents can get sick if not clean. During an interview on 6/25/25 at 3:48 p.m. with MT, MT stated both ice machines will be cleaned when he has time, and they are not cleaned on a specific day. MT stated it is important for the ice machines to be cleaned because ice goes to all residents, and they could get sick. During an interview on 6/27/25 at 8:59 a.m. with the Director of Nursing (DON), the DON stated the expectation is for the ice machines to be monitored by facility maintenance for cleanliness and to follow protocol. The DON stated both ice machines are used for residents. The DON stated it is important to ensure the ice machines are cleaned because residents can get sick. During a review of job description titled Maintenance Technician III dated 10/1/24, the Maintenance Technician III description indicated, .Position Summary: Provide high quality and specialized maintenance in the following areas: physical plant, machinery and equipment, and preventative and corrective maintenance. Includes specialized responsibilities in the areas of heating and cooling (HVAC), refrigeration . and other environmental services functions .During a review of job description titled Assistant Director, Facilities Management dated 10/1/24, the Assistant Director, Facilities Management description indicated, .Position Summary .Responsible for assuring compliance with all applicable local, state and federal statues and conformance with campus safety programs .Major Responsibilities: Assign and manage facilities management work order scheduling to ensure satisfactory and timely completion. Must be able to prioritize work and be proactive in noticing problem areas or jobs that need to be done in order to maintain organization standards .During a review of job description titled Director of Facilities Management dated 10/1/24, the Director of Facilities Management description indicated, .Position Summary . The facilities management director is responsible for assuring compliance with all applicable local, state and federal statues and conformance with campus safety

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow proper infection control practices for 1 of 4 sampled residents (Resident 5) when the nurse did not use Enhanced Barrier Precautions (EBP as gown, and gloves), while administering medications and a bolus feeding through a gastrostomy tube (G-tube- a small, soft tube that is inserted through the skin directly into the stomach, and is used to give food, water or medicine).This failure increased the risk of spreading germs amongst all residents in the facility. Findings:During a review of Resident 5's admission Record (AR- a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), Resident 5's AR indicated, Resident 5 was admitted to the facility on [DATE] with a diagnosis which included dysphagia (difficulty swallowing), cerebrovascular accident (CVA-a stroke, loss of blood flow to a part of the brain), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During an observation on 6/24/25 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 2 during medication administration observation task, LVN 2 administered medications and a bolus feeding via G-tube to Resident 5 and only wore gloves during the task.During an interview on 6/24/25 at 2:16 p.m. with LVN 2, LVN 2 stated the purpose of EBP was to prevent infections, reduce the spread of germs and protect the resident. LVN 2 stated EBP, which included wearing a gown and gloves, were used when caring for residents such as Resident 5 was at high risk for infection during such procedures due to her G-tube. During an interview on 6/24/25 at 3:13 p.m. with the Director of Nursing (DON), the DON stated EBP were required for any resident with wounds, catheters, IV's or G-tubes. The DON stated her expectation for staff was to wear EBP when providing direct care to residents with these conditions or devices. The DON stated wearing only gloves was not sufficient. The DON stated following EBP was important to prevent the spread of infections to others and to avoid exposing the resident to potential infections. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated 8/2022, the P&P indicated, EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply .examples of high contact resident care activities requiring the use of gown and gloves for EBP's include: g device care or use (feeding tube) .EBP remain in place remain in place for the duration of the residents stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .