Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0332	A. BUILDING: ______ B. WING ______	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT VILLAGE, INC	1351 ROBINWOOD ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS An unannounced onsite licensure survey was conducted on 10/14/25 through 10/16/25. Event ID # SJHH11.	L 000		
L 051	.2210(C) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (c) A facility shall investigate allegations of any act listed in G.S. 131E-256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary steps to prevent further incidents while the investigation is in progress. This Rule is not met as evidenced by: Based on observation, record review, and resident, family member, staff and Medical Director interviews, the facility failed to investigate an injury of an unknown origin for 1 of 1 sampled resident (Resident #3). Resident #3 was observed on 10/10/2025 to have bruising from her lip to her chin with swelling; the injury could not be explained by the resident and no one had observed the source of the injury. The findings included: Resident #3 was admitted to the facility 1/1/2023 with diagnoses that included paroxysmal atrial fibrillation. Resident #3's physician order dated 6/6/2025 revealed she was administered Eliquis	L 051		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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(medication used to prevent blood clotting) 2.5 milligrams (mg) twice daily.

Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 7/28/2025 revealed she had moderate cognitive impairment, required partial to moderate assistance with transfers, and was coded for the use of an anticoagulant.

Resident #3's care plan dated 7/25/2025 revealed a problem of potential hemorrhage related to anticoagulant therapy. The goal stated she was to remain free of signs and symptoms of hemorrhage as seen by no headaches, nose bleeds, coffee ground emesis, black tarry stools and excessive bruising. The approaches included administer Eliquis 2.5 mg orally twice daily, monitor Resident #3 for excessive bruising and report signs and symptoms to Medical Director.

Nursing progress note dated 10/10/2025 by Nurse #1 revealed Resident #3 had a blue bruise on the left lower jaw which was not present the previous day. Resident #3 did not know how the bruise occurred, and her cheek was sore. The note continued with Resident #3 had denied tooth pain and there was no evidence of facial drooping or other neurological signs. The note did not indicate the Director of Nursing (DON), Administrator or Medical Director were notified.

Interview with Nurse #1 10/15/2025 at 1:35 PM revealed he was assigned to Resident #3 on Thursday, (10/9/2025). While administering medication Nurse #1, noticed a bruise on Resident #3 face that appeared to be bluish in color, with no swelling, extended from the corner of her lip to beneath her chin and appeared to be fading. Nurse #1 asked the resident what happened, and Resident #3 stated that she did

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not know. Nurse #1 indicated he documented the bruise in Resident #3's chart but did not check to see if an "event" had already been completed. Nurse #1 included his observations of Resident #3's bruise on the 24-hour report for the oncoming nurse. He had not notified the supervisor or DON. The interview further revealed Resident #3 was receiving Eliquis, but Nurse #1 had not notified supervisor because there were no signs of active bleeding, neurological findings were normal, and the issue had been reported to the day shift. When he asked the NAs if they were aware of how Resident #3 sustained a bruise to her face, they stated they did not know.

An interview was conducted with Nursing Assistant (NA) #1 on 10/15/2025 at 8:43 AM. NA #1 revealed she was assigned to Resident #3 on Saturday (10/11/2025) and recalled there was a noticeable bruise on the left side of her mouth. She described the bruise as yellowish in color and it looked like it was in the healing stage. Resident #3 did not complain of pain and NA #1 stated she did not notice any swelling. NA #1 recalled that Family Member #2 asked her about bruising to Resident #3's face. NA #1 stated she told Family Member #2 she should speak to the nurse as she was not sure how it happened. NA #1 believed the nurse was already aware of the bruise to Resident #3's face, so she did not report it to the nurse.

Interview with NA #2 on 10/15/2025 at 8:48 AM revealed she worked with Resident #3 Friday (10/10/2025). She stated resident had a purplish yellow bruise on the left side of her face. She asked resident what happened, and resident told her that she bit the inside of her cheek. She did not mention it to the nurse because she thought

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that the nurse was already aware.

Review of the facilities incident/accident log for October 2025 revealed no incident/accident on 10/10/2025 for Resident #3.

Interview and observation of Resident #3 on 10/14/2025 at 2:02 PM revealed she had a yellowish bruise on the left side of her mouth. The bruise went from the corner of her mouth to right under her chin, left side of face appeared slightly puffy. Resident #3 stated she did not know how she got the bruise on her face.

An interview was conducted with the Administrator on 10/14/2025 at 3:25 PM. He revealed the bruise to Resident #3's left cheek coincided with her going out with Family Member #1 (POA) to the bank. The facility assumed Resident #3 got the bruise on her left cheek at that time.

Interview with DON on 10/14/2025 at 3:36 PM revealed nursing staff should complete an "event" for an injury of unknown origin. Nurses were expected to communicate with each other during shift change reports, and reporting conducted on every resident at least once per shift. Documentation of an "event" should be completed within 24 hours. The DON stated there was no "event" completed for Resident #3. An "event" should have been completed when Nurse #1 documented Resident #3 had a bruise to her jaw. She stated that no other staff had assessed Resident #3's bruise, and no staff interviews were conducted regarding the "event". If the "event" had been reported, she and the Administrator would have reviewed the "event" and conducted an investigation to attempt to determine the cause of Resident #3 facial bruising. The DON

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stated that she had not personally seen Resident #3's bruise. During a continued interview and observation of the resident with the DON at 3:42 PM Resident #3 had a bruise from her lip to the base of her chin. The DON was overheard to ask Resident #3 about her pain level. Resident #3 stated pain level to the left side of her face was a 3 (mild on the pain scale of 1 to 10). The DON was further overheard to ask Resident #3 how the injury occurred. Resident #3 stated it could have been from the bedside table but she did not know. The DON stated the physician was not notified because an "event" was not completed and it was a failure on Nurse #1's part for not completing an "event".

Interview with Family Member #1 on 10/14/2025 at 4:54 PM revealed he last saw Resident #3 on 10/10/2025 or 10/11/2025. He furthered revealed he took her out to the bank earlier that week but could not remember the exact day. Family Member #1 recalled Resident #3 having a puffy place on her face when he saw her earlier in the week and Resident #3 stated she bit the inside of her jaw. Family Member #1 indicated when he saw her again on that Thursday (10/9/2025) or Friday 10/10/2025) there was noticeable bruising, dark in color and more swelling. Family Member #2 saw Resident #3 on Saturday (10/11/2025) and sent Family Member #1 a photograph because Family Member #2 was concerned.

Interview with Family Member #2 on 10/14/2025 at 5:34 PM revealed she saw Resident #3 on Saturday (10/11/2025) and she immediately saw a bruise on Resident #3's left cheek. She described the bruise on Resident #3's face as purplish black, that appeared to be smudged black make-up. She further described the bruise as being 2 1/2 to 3 inches long, ½ inch to 1 inch

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in width about the size of a nickel to a quarter. Family Member #2 stated she lightly touched the bruise and Resident #3 stated it hurt. Family Member #2 indicated she went to nurses' station and asked a Nursing Assistant (NA) (name unknown) if they knew about Resident #3's face. The NA told Family Member #2 to speak with the nurse as the nurse could give her more information. There was not a nurse at the nurse's station and Family Member #2 did not inquire further about what had happened regarding Resident #3's bruised left cheek.

Interview with Administrator 10/16/2025 at 8:11 AM revealed his expectation was for staff to complete an "event" so that he and the Director of Nursing (DON) could begin an investigation. The investigation would include staff interviews, resident interviews and appropriate notifications. To his knowledge, an investigation had not been completed for Resident #3's injury of unknown origin.

Interview with Medical Director on 10/16/2025 at 9:23 AM revealed Resident #3 bruised easily due to being on a blood thinner, so the presence of a bruise would not be surprising or unusual to him. The Medical Director stated that he had not been notified about Resident #3 having a bruise to her face and it was his expectation the nursing staff would inform him of such occurrences.