PRINTED: 08/02/2023 FORM APPROVED OMB NO. 0938-0391

(X4) ID PREFIX (EAC	SUPPLIER	055983			(X3) DATE SURVEY COMPLETED	
(X4) ID PREFIX TAG (EAC REGI	SUPPLIER		B. WING		07/31/2023	
PREFIX (EAC TAG REGI	COVENTRY COURT HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2040 S. EUCLID AVENUE ANAHEIM, CA 92802		
F 000 Initial Com	CH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
Surveyor: The follow Departmer Emergenc The finding Federal Re for Long Te Represent Health: 43 The facility 42 CFR 48 Facilities. Census = 6 E 039 SS=D CFR(s): 48	ing reflects nt of Public by Preparedings are in acceptuations (Ferm Care (Lating the Caliston) is not in succeptual for Losson 1980. The Caliston 1980 of Requirements 1981. The Caliston 1981 of Requirements 1981 of Requirements 1981 of Requirements 1981. The Caliston 1981 of Requirements 1981 of Re			This Plan of Correction constitutes Court Health Center written evidence achievement of substantial compliance deficiencies shown on this Statement of ciencies (CMS-2567 dated 07/21/2023 ability to maintain substantial conthrough the monitoring of its quality as programs. Preparation and or execution of this Correction does not constitute admission agreement by Coventry Court Health of the facts alleged and/or conclusion son this Statement of Deficiencies. This Correction is prepared and/or executed the provisions of Health and Safety Cotton 1250 and 42 Code of Federal Reg 4005.1907 Part 483.70(a) life safet NFPA 101,2000 edition chapter 19 health care occupancies and other approaches the codes requires it	e of its of the of Defi- and its apliance surance Plan of on and/ a Center set forth Plan of because de, Seculations y code existing	
\$460.84(d) \$483.475(i) \$485.542(i) \$485.920(i) *[For ASCs at \$485.54 \$485.727, \$491.12, a (2) Testing to test the must do al	(d)(2), §482.1 (d)(2), §484. (d)(2), §485. (d)(2), §491. (s at §416.5442, OPO, "O, CMHCs at and ESRD F g. The [facilities emergency] Il of the followate in a full-	13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). I, CORFs at §485.68, REHs rganizations" under §485.920, RHCs/FQHCs at acilities at §494.62]: y] must conduct exercises plan annually. The [facility] wing: scale exercise that is ry 2 years; or		Immediate Corrective action(s) for dent(s) found to have been affected the deficient practice: The facility conducted a Tabletop Exon 9/7/2023 at 9:00 am. How other residents having the potential to be affected by the sandeficient practice will be identified what corrective action will be taked. All residents and employee of this facility the potential to be affected by these find.	ed by ercise ne d and en; have	

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		055983	B. WING	B. WING			31/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	040 S. EUCLID AVENUE			
COVENTR	Y COURT HEALTH CEN	TER		A	NAHEIM, CA 92802			
0/10/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X	(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE	
					DEFICIENCY)			
E 039	Continued From page	e 1	E(039				
	· -	ity-based exercise is not			What measures and/or systemic			
		facility-based functional			changes will be made to ensure to			
	exercise every 2 year				the deficient practice does not re-	cur;		
		experiences an actual			process to prevent recurrence:			
	. ,	•						
	natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2				The maintenance supervisor v			
					plan, schedule and hold these	ex-		
					ercises on an annually basis a	ınd		
					will share the documentation of			
					discussion or exercise outcom			
	years, opposite the ye				review to the administrator and	u		
		nder paragraph (d)(2)(i) of			QA&A committee.			
		eted, that may include, but is						
	not limited to the follo	_						
	(A) A second full-scal	•						
	` '	individual, facility-based						
	functional exercise; o	· •			How the corrective action(s) will l	<u>oe</u>		
	(B) A mock disaster d				monitored to ensure that solution	are		
	(C) A tabletop exercis	se or workshop that is led by			sustained and deficient practice v	vill		
	a facilitator and include	des a group discussion using			not recur, i.e. POC integration into			
	a narrated, clinically-r	elevant emergency			Quality Assurance Program to ev	_		
	scenario, and a set of	f problem statements,			effectiveness:	<u></u>		
	directed messages, o	r prepared questions			<u>chediveness.</u>			
	designed to challenge	e an emergency plan.						
	(iii) Analyze the [facili	ty's] response to and						
	maintain documentati	ion of all drills, tabletop				_		
	exercises, and emerg	ency events, and revise the			The QA&A committee and adr	nin-		
	[facility's] emergency	plan, as needed.			istrator will discuss and review	the /		
					process on a quarterly basis to	o en-		
	*[For Hospices at 418				sure that the protocols set fort			
		es that provide care in the			within these corrective measu			
		hospice must conduct				162		
		emergency plan at least			are followed.			
		e must do the following:						
		l-scale exercise that is						
	community based eve							
	(A) When a communi	ty based exercise is not						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG 02		(X3) DATE SURVEY COMPLETED		
		055983	B. WING _			07/31/2023	
	ROVIDER OR SUPPLIER RY COURT HEALTH CEN	ITER	,	STREET ADDRESS, CITY, STATE, ZIP C 2040 S. EUCLID AVENUE ANAHEIM, CA 92802	•		
(X4) ID PREFIX TAG			ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
E 039	functional exercise e (B) If the hospice exponent of the emergency plan, engaging in its next of community-based expacility-based function onset of the emerger (ii) Conduct an addition onset of the exercise under paragis conducted, that may to the following: (A) A second full-scar community-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator and inclusing a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (3) Testing for hospic care directly. The hospice of (i) Participate in an ais community-based; (A) When a community-based; (A) When a community-based function (B) If the hospice exponent of the emergency plan,	an individual facility based very 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale recise or individual nal exercise following the ney event. icional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited ale exercise that is a facility based functional drill; or ise or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions e an emergency plan. ese that provide inpatient respice must conduct emergency plan twice per nust do the following: annual full-scale exercise is not an annual individual	EC	039			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		055983	B. WING			07/	31/2023
	ROVIDER OR SUPPLIER Y COURT HEALTH CEN	TER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 040 S. EUCLID AVENUE NAHEIM, CA 92802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	(ii) Conduct an additimay include, but is not (A) A second full-sca community-based or exercise; or (B) A mock disaster of (C) A tabletop exercifacilitator that include narrated, clinically-rel and a set of problem messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentatic exercises, and emergency hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or man requires activation of [facility] is exempt from required full-scale contents.	d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. vice's response to and on of all drills, tabletop tency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must or ty-based exercise is not an annual individual, all exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next mmunity based or individual, all exercise following the	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02				ATE SURVEY OMPLETED		
		055983	B. WING _			07/31/2023
	ROVIDER OR SUPPLIER	TER .	STREET ADDRESS, CITY, STATE, ZIP CODE 2040 S. EUCLID AVENUE ANAHEIM, CA 92802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 039	and that may include, following: (A) A second full-sca community-based or if functional exercise; or (B) A mock of (C) A tabletop existed by a facilitator and discussion, using a nate emergency scenario, statements, directed in questions designed to plan. (iii) Analyze the [imaintain documentatic exercises, and emergency sercises, and emergency are plan. *[For PACE at §460.8 (2) Testing. The PACE of continuity and is community. The PACE of following: (i) Participate in an and is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experimentation of the emergency plan, in the emergency plan, in the exercise following the event. (ii) Conduct an accessible of the event. (iii) Conduct an accessible of the event. (iii) Conduct an accessible or individual, face exercise following the event. (iii) Conduct an accessible or individual and individ	additional] annual exercise or but is not limited to the le exercise that is ndividual, a facility-based relisaster drill; or ercise or workshop that is includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the mual full-scale exercise that or ty-based exercise is not n annual individual,	EO	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
		055983	B. WING			07/	/31/2023
	ROVIDER OR SUPPLIER RY COURT HEALTH CEN	TER	•	2040	EET ADDRESS, CITY, STATE, ZIP CODE D S. EUCLID AVENUE AHEIM, CA 92802	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	exercise under paragis conducted that may the following: (A) A second full-sca community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercial facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC maintain documentate exercises, and emergency paragination of the following unannounce emergency procedure (CF/IID) must do the following unannounce emergency procedure (ICF/IID) must do the following unannounce emergency procedur	raph (d)(2)(i) of this section y include, but is not limited to alle exercise that is individual, a facility based redrill; or see or workshop that is led by des a group discussion, ically-relevant emergency for problem statements, or prepared questions an emergency plan. E's response to and ion of all drills, tabletop gency events and revise the lan, as needed. It §483.73(d):] must conduct exercises to lan at least twice per year, and staff drills using the less. The [LTC facility, following: Innual full-scale exercise that or ty-based exercise is not an annual individual, anal exercise. If facility experiences an emade emergency that the emergency plan, the from engaging its next	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION NG 02		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
E 039	functional exercise; of (B) A mock disaster (C) A tabletop exercise a facilitator includes a narrated, clinically-re and a set of problem messages, or prepar challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §48 (2) Testing. The ICF/to test the emergence The ICF/IID must do (i) Participate in an a is community-based; (A) When a communaccessible, conduct a facility-based function (B) If the ICF/IID exp man-made emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additional may include, but is next of the incommunity-based or functional exercise for emergency event. (iii) Conduct an additional exercise; (B) A mock disaster (B) A mock disaster (B) A mock disaster (B) A mock disaster (C)	ale exercise that is an individual, facility based or drill; or ise or workshop that is led by a group discussion, using a levant emergency scenario, statements, directed ed questions designed to ency plan. C facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. 3.475(d)]: IID must conduct exercises y plan at least twice per year. the following: nnual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from required full-scale individual, facility-based ollowing the onset of the onal annual exercise that ot limited to the following: le exercise that is an individual, facility-based or	E	039		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		055983	B. WING _			07/	31/2023	
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E 039	using a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/III maintain documentati exercises, and emerging ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The Histo test the emergency least annually. The Histo test the emergency least annually. The Histo in a full-community-based; or (A) When a community-based function or. (B) If the HHA export the emergency planengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paraging is conducted, that limited to the following (A) A second full-community-based or functional exercise; of (B) A mock disast	les a group discussion, cally-relevant emergency is problem statements, or prepared questions an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the plan, as needed. O2] HA must conduct exercises or plan at the HA must do the following: escale exercise that is exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale endividual, facility based ellowing the onset of the enal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section at may include, but is not great exercise that is an individual, facility-based or ter drill; or ercise or workshop that is	EC	039				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		CONSTRUCTION !	(X3) DATE SURVEY COMPLETED		
		055983	B. WING			07/	31/2023
	ROVIDER OR SUPPLIER	TER	•	20	REET ADDRESS, CITY, STATE, ZIP CODE 40 S. EUCLID AVENUE NAHEIM, CA 92802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	discussion, using a nate mergency scenario, statements, directed questions designed to plan. (iii) Analyze the HHA'documentation of all demergency events, a emergency plan, as not a temporal to test the emergency following: (i) Conduct a paper-bound workshop at least and led by a facilitator and discussion, using a nate mergency scenario, statements, directed questions designed to plan. If the OPO expending in its next refollowing the onset of (ii) Analyze the OPO'documentation of all for the plan is the opt of the opt o	arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency as response to and maintain drills, tabletop exercises, and not revise the HHA's needed. 360] PO must conduct exercises or plan. The OPO must do the mased, tabletop exercise or nually. A tabletop exercise is dincludes a group arrated, clinically relevant	E	039			
	must do the following (i) Conduct a paper-b least annually. A table	18]: NHCl must conduct emergency plan. The RNHCl					

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E 039	of problem statement prepared questions demergency plan. (ii) Analyze the RNHO maintain documentati and emergency even emergency plan, as not a secondary full-sociated to program work a secondary full-sociated to program work a secondary full-sociated to propare with the testing program work a secondary full-sociated to propare with the testing program work a secondary full-sociated to propare with the testing program work a secondary full-sociated to propare work and the program work and the testing program work a secondary full-sociated to propare work and the program	ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, ts, and revise the RNHCI's needed. The ward interview, the facility Emergency Operations Plan enced by missing ticipation in a nergency exercise. This dents and could result in the properly react in the event of each of the EOP testing on was requested. The of the EOP revealed that was missing documentation ale, mock disaster, or on interview, the ed the finding and stated hired at the facility and was letop exercise was		0000			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		CONSTRUCTION !	(X3) DATE SURVEY COMPLETED		
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K 000	Continued From page	÷ 10	K	000			
	K3 BUILDING: 01 K6 PLAN APPROVAL K7 SURVEY UNDER						
	STRUCTURE TYPE: CONSTRUCTION TY SPRINKLERED.						
	Resident Certified Be Resident Census: 80	ds: 97					
	Department of Public Life Safety Code rece findings are in accord Federal Regulations (National Fire Protection	the findings of the California Health, during an annual ertification survey. The ance with 42 Code of (CFR) §483.90(a)(b)(c)(j), on Association (NFPA) 101 - 2 Edition, and NFPA 99 - Code, 2012 Edition.					
	Representing the Cal Health: 43035	ifornia Department of Public					
	-	rantial compliance with 42					