

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

1231

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/05/2013
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NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040
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(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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Covenant Shores on 03/05/13. A sample of 11 residents was selected from a census of 36. The sample included 6 current residents and 5 former residents.</p> <p>The survey was conducted by:</p> <p>██████████ MN, RN ██████████ MA, RD, CD ██████████ BSN, RN</p> <p>Complaints Investigated Included: #2763689 #2762051</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, Region 4, Unit B Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p><i>Lois Ransom</i> 3/12/13 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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F 000	Continued From page 1	F 000		
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to properly log and thoroughly investigate 6 of 6 incidents for 6 residents reviewed, in accordance with state law and federal regulations 42 CFR483.13 (c)(2) and (3). Failure to properly log all components of incidents according to regulation resulted in an inability to easily track similar occurrences, findings and actions taken for affected residents. The lack of thorough investigations and analysis of incidents prevented the facility from determining if abuse/neglect occurred and placed the residents at risk for abuse/neglect, unmet care needs and/or reoccurrence of incidents and injury.</p> <p>Findings include:</p> <p>Unless otherwise noted, all interviews took place on 03/05/13.</p> <p>REPORTING LOG</p> <p>On entry to the facility at 8:40 a.m., the Director of Nursing (DON) was asked to provide the past 6 month ' s investigative reporting log. What was provided was titled "Occurrence Log". The first Occurrence Log only included residents who had experienced falls. The second log listed residents who had experienced falls, bruises, and/or skin tears. Neither log included all the components as</p>	F 225		

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Continued From page 3  
dictated in the Nursing Home Guidelines' "Purple Book, Appendix P". The logs did not include information to determine the type of injury, the findings or actions taken by the facility for each occurrence. A third log was provided that was referred to in the facility's "Abuse Prevention Program" policy, called the "Riskwatch". This log contained, in addition to information on the other logs, a conclusion statement and a statement on the "immediate actions taken." This log did not include all components either.

In an interview with the DON at 1:20 p.m., when asked about the logging of different components as outlined in the "Purple Book" she reported she thought the Occurrence Logs identified all the necessary components. In review of the form, she agreed all information was not on the form. The DON provided an investigation for Resident #4's fall that resulted in a fracture of the [REDACTED]. The investigation itself included all the logging components but the actual log entry did not.

**THOROUGH INVESTIGATIONS**

The DON at 9:00 a.m. was asked to provide all the investigative paperwork, including staff interviews and evidence to rule out abuse and neglect for falls by Residents #1, #2, #3, #4's and #6 and a bruise for Resident #5. For each incident one piece of paper was provided.

Resident #1 had [REDACTED] and would frequently pace in the afternoons, wandering into other resident's rooms. The resident had a number of falls over the past few months. The resident was observed in the hallway walking with an aide around 2:00 p.m. The investigation dated

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**F255**

- Resident #1: It was reported by the nurse that the resident had fallen during the activity while dancing to the music. Through the investigation per our Riskwatch state log indicates the findings of reasonably related (#81) and origin established (#80). Abuse (#85) was not selected as there were no findings of abuse.
- Resident #2, 3, 5, and 6: Abuse (#85) was not selected as there were no findings of abuse. The facility has started to add additional documentation to assist in clarifying any question regarding abuse/neglect.
- Resident #4: Vital signs are clearly stated on report. Resident alert and oriented unmistakably knows what happen. Investigation report states resident's statement of resident trying to close curtain lost her balance and fell.

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F 225	<p>Continued From page 4 around 2:00 p.m. The investigation dated 01/17/13 included basic information related to what happened and where it happened, vital signs, notes from a nurse and a conclusion statement. The report did not rule out abuse/neglect or clearly identify how the resident fell or additional staff interviews.</p> <p>Resident #2 suffered from [REDACTED] and had frequent falls related to standing up independently or tripping over the wheelchair foot rest. He was observed sitting on the side of his bed around 2:00 p.m. He tried to stand and the alarm sounded to alert the staff. The investigation of 12/10/12 was similar to the above investigation.</p> <p>The investigations for Resident #3's fall on 12/29/12, and #6's fall on 01/07/13 were similar and did not identify that abuse/neglect had been ruled out.</p> <p>Resident #4 fell on 02/01/13 which resulted in a fracture of her [REDACTED]. This investigation included more details related to actions taken but did not include vital signs or other measures to rule out medical conditions or room conditions that might have resulted in the fall.</p> <p>Resident #5 had a bruise on her right upper arm that was noted on 01/27/13. In an interview with her at 10:30 a.m., she remembered the bruise and that it just appeared one day. She said, "It was red, swelled up and was hard. It gradually went away." She reported no staff mistreatment and that she used the wheelchair and walker to get around. In a review of the physician progress note of 01/29/13, the bruise was not addressed.</p>	F 225	<p><u>How deficiency is corrected:</u></p> <ul style="list-style-type: none"> <li>The facility log contains all the components of the "Reporting Log" except whether the hotline was notified. The facility has contacted the vendor for the Riskwatch program for correction.</li> </ul> <p><u>Action to protect residents:</u></p> <ul style="list-style-type: none"> <li>Until this correction is completed by vendor, beginning 3/6/13 the facility will utilize the Appendix E form provided in the "purple book" for logging of required incidents.</li> </ul> <p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> <li>Policy and Procedure on investigations/report allegations/individuals reviewed 3/6/13 and will be updated as needed.</li> </ul>	
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F 225	<p>Continued From page 5</p> <p>The DON and Staff members A and B, from the physical therapy department, reported in separate interviews, they had discussed the resident's bruise and had determined the plausible cause of the bruise. This documentation was not found in the investigation. There was no documentation ruling out abuse/neglect.</p> <p>In an interview with the DON at 11:00 a.m., when ask to describe her process of investigation of incidents she reported, she follows the "Purple Book", interviews the resident, interviews the past 3 nursing and aide shifts and that if the resident knows how the incident ocured, she stops investigating. She reported, "I only keep track of the nurse, nurses aide, witness and resident statements. I don't write down the other statements and investigation pieces."</p>	F 225	<p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> <li>▪ Facility will continue with weekly review investigations/ report allegations/individuals and monthly review of trends related to investigations/report allegations/individuals.</li> </ul> <p><u>Dates corrective action complete and responsible person:</u></p> <ul style="list-style-type: none"> <li>• Corrective action will be complete on 4/15/13 by Director of Nursing</li> </ul>
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